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A Symbol

ON A GREEN HILLSIDE, six miles from Oxford, is the little village of Islip. Before the war it was not noted for anything. Here in this peaceful countryside lived Dr. James and his wife, both trained botanists. Their home was a little farm of a few acres.

Islip came to have national importance because of Dr. James. With the outbreak of war, England found herself critically short of a number of important drugs, among them digitalis and belladonna. Dr. and Mrs. James made up their minds to do something about it.

Word was sent around to the schools and women's organizations that the foxglove and the deadly nightshade were plants badly needed for the sick in England. Would the women and children help? Would they go out over the countryside and gather leaves from these plants and bring them to Dr. James's farm?

The response was immediate. Boys and girls, mothers and fathers came on foot, on bicycles, and in all manner of conveyances bringing their baskets of precious leaves. All were carefully picked and packed according to directions.

Dr. and Mrs. James turned their stable into a drying house. Wire trays on which to dry the leaves were made by hand. Stoves were set up and the temperature of the stable carefully controlled, so the leaves would not spoil or lose their valuable drug content. As fast as the fresh, green leaves poured in from the countryside, voluntary workers prepared them for drying. Other workers packed the carefully dried leaves and shipped them to a drug firm in London. The emergency was met. England found herself with enough digitalis and belladonna to meet the needs.

In the meantime, Dr. and Mrs. James found time to cultivate healthy plants. With their skill in selection and cross-fertilization, they soon converted their few acres into one of the most famous drug farms in England.

Looking at this little farm a few weeks ago, with its small, old-fashioned

house and sagging stone stable, it was hard to realize that from this unpretentious place, totalling lacking in equipment, came important material that helped save the lives of many Britons. The small efforts of many were fused into a far-reaching whole.

Dr. James and his little drug farm epitomizes the efforts of many people in England, and in Canada, too, during a most difficult period. They are a symbol of what can be done when many co-operate and their efforts are well directed.

The Canadian Nurses' Association is such a symbol. It represents the work of many thousands of nurses across Canada whose efforts are guided by a small group of officers and a national office. During the war years, the individual nurses of Canada contributed their services so generously that the combined effort added up to a tremendous whole. This great co-operative effort received generous help and effective direction from a small staff at national headquarters.

It is difficult to pull out the threads in the fabric of the whole. Married and retired nurses left their homes and came forth to help in the emergency. Schools were enlarged; additional instructors were found; university courses were expanded to meet the needs; nurses took on all manner of jobs that meant better care for the sick; well-planned publicity aided in the recruitment of nurses; careful surveys of nursing needs were made; and many projects were made possible because of generous grants from the Canadian Government. The combined efforts produced results of which any Canadian may be proud. Our war wounded and civilian sick received nursing care that stood second to none in any part of the world.

But the need is not yet over and we are still in the midst of emergency. Veterans hospitals across Canada require large numbers of nurses. Public health fields are expanding with increased social services. Hospitals are overflowing with patients as people demand better medical care than they have had ever before.

There is a great dearth of nurses to meet all of these demands. We still need the help of all those who gave so generously during the war years. If it cannot be a full-time job, let it be a part-time one. Everyone's little effort will turn the wheel.

In the midst of all these demands the Canadian Nurses' Association is aware that the time has come for a new deal in nursing education. Plans for this new deal have already been made. It is hoped that some experiments in new types of schools will materialize in the near future, and that these schools may demonstrate what can be done to educate nurses to meet the changing health picture in Canada. Improvements in working conditions and in salaries must go along with improved education.

The problem then that lies before us is twofold. We must meet the demands for nursing care as best we can now, and, at the same time, we must be mindful that changing conditions are demanding drastic changes in the education and employment of nurses. The problem can be solved if we all work together, and, above all, if we are open-minded and understanding.

RAE CHITTICK
President
Canadian Nurses' Association

Coming Events

Event: Series of X-Ray courses for Alberta nurses.

Place and Date: St. Michael's Hospital, Lethbridge, Oct. 28-Nov. 1 inclusive; Dr. W. H. McGuffin, 224-7th Ave. W., Calgary, Nov. 4-8 inclusive; University Hospital, Edmonton, Nov. 11-15 inclusive; Grande Prairie Hospital, Peace River District, Nov. 18-22 inclusive.

Hours of lectures—2-5 p.m. and 7-10 p.m. daily.

These courses are being planned and given by the Victor X-Ray Company.

Heart Disease in Children

A. L. Donovan, M.D.

Congenital Heart Disease

Heart Disease in children falls into two groups—*congenital* and *acquired*. In consideration of this first group, the only really important forms are patent ductus arteriosus, tetralogy of Fallot, and coarctation of the aorta; these may be benefitted or cured by surgery. Congenital heart disease is that condition in which, as a result of malformation, there are symptoms or signs of heart disease. These malformations may result from arteriovenous shunts of blood from one chamber to another as seen in septal defects and with patent ductus and stenosis or transpositions of the great vessels. As many different combinations of lesions may be present, detailed classifications are unnecessary. In regard to the clinical and nursing viewpoint, it is sufficient to remember that the classification falls into two main groups—the cyanotic and the acyanotic. If the defect is merely a mechanical obstruction of blood flow and there is no pulmonary systemic shunt, then no cyanosis can occur. The next group of defects is in the septum of the heart or in the aorta. If the pressure in the systemic circuit remains above that in the pulmonary, no cyanosis can occur. If, on the other hand, there is failure of the left heart or increased pulmonary pressure, then the cyanosis will occur. When the cardiovascular septum is absent or transposition of the great vessels is present, cyanosis will be present as it will also be with arteriovenous shunts.

Etiology: Congenital heart disease is usually associated with other defects and any abnormality elsewhere should suggest investigation of the heart. This is particularly true with mental deficiency. Heredity may play a part as this condition may be seen in successive generations. Some virus infection in the mother during the first trimester, notably *Rubella*, has been shown to have a definite influence. Maternal impressions or injuries have no place in this consideration. Infections of the mother may produce myocardial and endocardial lesions. These are not congenital defects.

Signs and symptoms: The condition may be obvious at birth or may not be discovered until late in life and then only accidentally. The two important symptoms are cyanosis and dyspnea and if these are present the diagnosis is suggested. The signs may be many and striking without symptoms. Anatomical diagnosis is important as the type of defect must be known.

Diagnosis: These comprise about 1 per cent of all heart diseases. The presence of cyanosis, as stated above, is suggestive. The history is most important, especially if that of "blue baby" at birth. Also important are dyspnea, weakness, and poor development, with or without defects. The cyanosis of the nails and lips is looked for especially and may be present only on crying or exertion. If present, there is usually a slaty color to the skin. Complete clinical examination of the heart, with the added information received from roentgenological and electrocardiographic studies, is most essential in the attempt to reach the proper diagnosis.

Prognosis: This must be guarded as it depends on the anatomical lesion. If, as stated before, a patent ductus is present, the condition may be cured. The amount of cardiac reserve determines the outlook and this depends on the mechanical obstruction to be overcome. These cases are very prone to respiratory infection and a large percentage develop subacute bacterial endocarditis and may have superimposed rheumatic heart disease. If the lesion is severe, with cyanosis and dyspnea marked, few survive the first

year of life. It may be noted that even those who do comparatively well and are compensated may die suddenly.

Treatment: This depends on the type of lesion and may be divided into *operative* and *non-operative*. The point of view of the operative has been discussed. The non-operative group must be managed as in any cardiac disorder, being most mindful to prevent, if possible, all respiratory infection. If these cases survive the first year of life, their greatest threat is from infection. Therefore, all foci of infection must be removed. It is considered, as in rheumatic heart disease, good treatment to use the sulfa drugs and penicillin during the removal of foci of infection. In the cyanotic child, treatment is palliative. The degree of activity must be guarded by the cardiac reserve and competitive sports should be discouraged. However, in the fairly well-compensated individual they should not necessarily be invalided. These individuals must be taught to measure their cardiac reserve and not proceed beyond the bounds to dyspnea. For failure, the routine treatment for heart failure must be instituted. If subacute bacterial endocarditis develops, adequate and early treatment must be carried out, since this condition, once 100 per cent fatal, is curable in more than one-half the cases with large doses of penicillin.

Summary: Congenital heart disease is not common and is often associated with other congenital anomalies. Early diagnosis and anatomical classification of the lesion should be made, as surgery may cure the condition. The outlook is as in any cardiac disorder and depends on the cardiac reserve. The patient must be protected from acute infections and the possibility of a superimposed subacute bacterial endocarditis must be constantly borne in mind, especially now when such favorable results are to be had with prolonged doses of penicillin.

Acquired Heart Disease

Rheumatic fever is the cause of most cases of organic heart disease and accounts for 90 per cent of cases prior to the twenty-fifth year. It is present in 1 per cent of all school children. It is the cause of death in the ratio of 8:1 as compared with anterior poliomyelitis. Recurrences are the rule rather than the exception as seven out of ten cases have repeated attacks. It is one of the chief scourges of youth. The term acute rheumatic fever limits the conception of the picture since only a minor percentage present the typical features. Many cases are atypical with no joint changes that are obvious, with little fever, and yet they are equally as capable of producing serious heart lesions as are severe cases with fever and polyarthritis.

The condition should be considered as a rheumatic state of which typical acute rheumatic fever, with all its signs and symptoms, is but one variety.

Etiology: Hemolytic infection (respiratory) usually precedes an attack. In cases under close observation, when throat cultures for hemolytic streptococcus became positive that were previously negative, attacks followed. This rheumatic state may occur in epidemics in overcrowded areas. There is a definite familial tendency towards it. Age incidence is usually five to nine years. The earlier the attack the greater the liklihood of recurrence and of cardiac involvement. It is a disease of the temperate zone, being rare in the tropics. It is more prevalent among the underprivileged, in overcrowded homes, and in those with low vitamin C intake.

Pathology: Like tuberculosis, rheumatic infection may produce characteristic lesions in many parts of the body. The typical lesion is a nodule, the so-called Aschoff body. These are present in the myocardium in probably all cases and they may be widely spread. They have a typical microscopic appearance and are found near the blood vessels. They may invade the body tissues. With healing, there is a scar tissue formation, contraction, and deformity. This is particularly evident in the endocar-

dium where the valves are contracted, thickened, or destroyed and the orifice is later stenosed. The subcutaneous nodule is similar on inspection to the Aschoff body and it may disappear quickly. The various effusions affecting the synovial and serous surfaces soon disappear.

Signs and symptoms: These may be many and varied depending on the presence of the typical or atypical picture. In typical rheumatic fever, the elevated temperature with polyarthritis migratory in nature, sweats, rapid weak pulse, increased white count are characteristic. This, however, is the exception rather than the rule in children. There may be no pronounced arthritis in children and the onset may be insidious with loss of weight, anorexia, fatigue, pallor, myalgia, and slight evening fever. The nervous child suggests a rheumatic infection especially if there is a history of choreiform movements. Sore throat or any upper respiratory infection often heralds the onset.

Diagnosis: Since there is no test that is diagnostic, the diagnosis depends on the clinical findings, history, and subsequent course. Clinically, the signs and symptoms may be divided into three groups according to their importance:

A. *Specific:* 1. Valvular heart disease in children, that is not congenital in origin, with polyarthritis and fever.

2. Sydenham's chorea followed by heart disease or occurring in a rheumatic fever family.

3. Subcutaneous nodules: (a) These are always seen in children but may be absent in adults; (b) the nodes may be over any bony prominence, usually the elbows or knees but may be on the spine or head; (c) they are subcutaneous and are not attached to the skin or bone but may be attached to the tendons.

4. Prolonged P-R interval. Diphtheria will give the same result.

B. *Suggestive:* (1) Multiple joint pains that in children may be slight whereas in adults they are pronounced; (2) pericarditis—always suggests a rheumatic state; (3) erythema marganitum; (4) unexplained epistaxis; (5) rapid pulse rate; (6) myalgia.

C. *Remote:* (Non-specific manifestations): (1) fever (should be by rectal temperature); (2) sedimentation rate is always elevated; (3) unexplained loss of weight; (4) pallor; (5) precordial pain (not related to activity); (6) backache; (7) tiredness.

Diagnosis is easily made if the specifics are present. The typical rheumatic fever, with migratory polyarthritis and the accompanying leukocytes, sweats, rapid pulse, and increased sedimentation rate usually presents all the features of the specific group. These are not a problem as they are readily recognized. To a lesser degree this is also true of the subacute variety. It is the atypical cases without joint involvement, with low-grade fever, periodic epistaxis, gastro-intestinal upset and weakness that present the diagnostic problem. These atypical cases may go unrecognized and then the serious damage is recognized too late. In the groups represented by the Suggestive and Remote, complete investigation, including history, clinical examination, roentgenoscopic examination, and electrocardiographic studies, must be carried out. Sedimentation rate is important in diagnosis and prognosis.

Prognosis: The immediate prognosis is good as, even in the severe types, death rarely occurs. The subsequent prognosis is difficult, if not impossible to determine, as the most severe case may have little ultimate damage. It is, however, safe to assume that the younger the patient the more likely and severe the disability. The presence of rheumatic nodules frequently forecasts a poor prognosis as these cases generally have serious cardiac damage. The number of attacks usually bears a direct relation to the amount of damage but where a number of attacks has caused little damage one may assume that future attacks will not be severe. In the unrecognized and untreated case, the prognosis is not good and this is also true if the recognized case is permitted activity too early. Multiple respiratory infection affects the prognosis adversely and the superimposed subacute bacterial endocarditis is of

grave importance. Environment is also of utmost significance.

Treatment: There is no specific treatment. Salicylates do not alter the occurrence of cardiac lesions; they only relieve the symptoms and shorten the febrile period. Sulfa drugs and penicillin have no place in the acute phase although they play a part in subsequent infections. Proper nursing care and bed rest will accomplish much. This can only be successful, however, with full co-operation from the family, to whom the condition must be fully explained. Treatment must be considered in three phases: acute, asymptomatic, and convalescent.

The *acute* phase, with the accompanying arthritis, fever, sweats, etc., requires the same care as any acute infection. Salicylates must be used freely as they may relieve the joint symptoms quickly and so lessen this discomfort. They may be continued for two weeks after the fever subsides. Their administration must be intelligently watched and if possible the blood level determined. Local treatment of the joints with methyl salicylates is apparently effective. The patient is better between blankets than sheets if sweats are a feature. Sedatives must be given for pain. If congestive failure occurs, it is cared for as in the ordinary case. If edema is present, a mercurial diuretic must be given with care, as it may elevate the salicylate blood level. Complete rest in this phase is essential. The diet is that which is best tolerated by the patient, but it must be adequate.

The *asymptomatic* phase includes both the case in whom the acute symptoms have subsided and the atypical case which has few symptoms. Here, rest is of paramount importance and it should be absolute. The length of the period is indefinite, depending on the cardiac damage which may be evident, and the behavior of the sedimentation rate. The sleeping pulse rate should be followed. The leukocyte count may be misleading but should be normal. No one sign, symptom, or test is indicative of the complete arrest of the disease. It is safe, however, to assume that all cases require bed rest for two or three months and those with evident cardiac damage much longer. The slowing of the pulse rate, the normal leukocyte count, the normal sedimentation rate, and gain in weight all suggest that the quiescent period is reached or near and that the third phase is reached. Developing secondary anemia suggests a recurrence.

The *convalescent* phase may be long and depends on the individual case. If a residual endocarditis is present the amount of activity depends on the cardiac reserve. Should no lesion be demonstrated, earlier return to activity may be permitted, but under strict supervision with frequent examinations. Environment being important, the underprivileged should have prolonged hospitalization where educational facilities are provided. Recurrence of symptoms with acute congestive failure may occur during this phase and this condition must be treated as described. Prevention must be considered here, as well as subsequently. This may only be accomplished by the avoidance of upper respiratory infection as far as possible, daily rest periods, the use of sulfa drugs and penicillin at the time of removal of foci of infection, and proper hygienic surroundings, as all these bear a direct relation to future health. The damaged valve or valves are always a possible site for subacute bacterial infection and this point must be remembered. It is important to note that the rheumatic heart, with a damaged mitral valve, often develops congestive failure but with proper care usually becomes compensated again.

Summary: The term acute rheumatic fever covers only a small group of the patients afflicted with rheumatic heart disease. The onset is usually heralded by acute respiratory infection. The atypical rather than the typical form is being stressed since it is here that most errors are made. There is no specific diagnostic test as the diagnosis depends on history, clinical course, and ultimate pathology. There is no specific treat-

ment and rest till the complete infection is eradicated is all-important. Complications, such as acute congestive failure and subacute bacterial endocarditis, must be treated promptly. The ultimate cardiac damage cannot be foretold.

Alterations in the Heart by Acute Infections

Children suffering from any acute infection, particularly diphtheria, may develop changes in the heart. This may involve the endocardium, myocardium, or pericardium. These changes may be due to the presence of a toxin in the blood stream or a bacterial invasion.

The etiology is dependent on the organism causing the acute infection. The onset is usually manifested by dyspnea, precordial pain, fever, and elevated pulse rate. The physical signs depend on the extent of the damage and the chief importance here is to remember that it *may* occur. Clinical evidence may be absent but delayed convalescence suggests investigation of the circulatory system. Physical examination usually will disclose the complications but electrocardiographic studies are often necessary to confirm the suspicion. Appreciation of this is important as these cases are more prone to recurrences during the acute infectious diseases. This group includes many of the cardiac emergencies in children which require the same treatment as has been outlined.

Various other cardiac conditions may be found but they are rare and of scientific interest only. They are mentioned only because they do occur and some of these are: sudden death from coronary insufficiency, paroxysmal tachycardia, luetic endocarditis, premature arteriosclerotic heart disease, bundle branch block, and any type of arrhythmia. One rarely encounters these conditions in children.

Nursing Care of Children with Heart Disease

Kathleen Bell

What is the aim in the treatment and nursing care of children with heart disease? Our purpose is to cause less strain on an already overtaxed heart muscle, to build up its reserve force, and to assist the child to lead a useful and happy life. The child, in spite of his illness, is a growing individual—growing physically, mentally, emotionally, and socially. It is our duty as nurses, during this important period in the child's life, to see that these growing needs are adequately met while he is in an institution such as the hospital.

Meeting Emotional Needs

Children are so much the products of their environment. By keen observation in the admitting room, we can detect often the lack of emotional stability in the parent, as well as in the child. He may have been threatened with doctors and nurses and, therefore, has a real fear. This fear of the unknown and the sense of insecurity causes the child to react in many undesirable ways. The nurse's task is to try to dispel these fears by making every effort to understand the child and his reaction and thus establish a sense of security in him. This is most essential when we are trying to do all in our power to lessen the work of such a vital organ as the heart. Even though the child is a patient in the hospital, away from the love and protection of the home, no matter how inadequate it may be, he can be loved and respected by the nurse. Children need this love and they will not be harmed by it unless it is unwisely

manifested to them. The nurse must know the meaning of tears and do all in her power to prevent them in the acutely ill child. Rest of mind is necessary to bring about rest of body. The room should be bright, cheerful, and quiet.

The child with chorea, as a manifestation of rheumatic infection, presents a real nursing problem in meeting his emotional needs. The movements of the nurse must be quiet and all excitement avoided. The attacks are aggravated by repression and by mental stress of excitement and embarrassment.

As the acute symptoms subside the child can withstand some emotional strain without undue damage to the heart. Visits by parents do cause excitement; therefore, they should be very infrequent and of short duration. However much the child is upset after the parents leave, it is still found necessary in most children's hospitals to allow these visits at least once a week.

Meeting Social Needs

The infant with congenital heart disease will not require much guidance in meeting his social needs but with an older child this is a very important factor. I once heard a little girl say that the only time she did not like the hospital during her long stay there was during the first two weeks when she was placed in isolation. Children are sociable beings and, no matter if they are in hospital, they require the companionship of other children.

In a world where so much emphasis is placed on getting along well with our fellows, it is important that we instil the idea in the children at an early age. The child may be acutely ill and not be concerned with others at first, but as convalescence progresses the nurse must try to see that group games, songs, story-telling, and work are instituted. Our cubicle system in hospitals has done much to isolate children, but at the same time the glass partitions allow them to see and hear other children, which helps them to adjust in a satisfactory social manner.

Meeting Mental Needs

The child in either the acute or chronic stages of heart disease is an individual with a mind to be developed. This is where the school teachers and occupational therapists fit into the nursing picture. Nurses must co-operate wholeheartedly with those who are helping children to become useful and happy citizens. By means of various tests, such as sedimentation rates, electrocardiograms, and the pulse rate, the nurse can help the therapists and teachers to grade the children's activity. The child is taught many arts and handicrafts to help him to use his spare time to good advantage, even to earning a living in adult life. He must be taught to understand his limitations and capacities, and to make the most of them. The whole atmosphere created by everyone should contribute to repose and a healthy mental attitude.

Meeting Physical Needs

By physical needs we mean all those things that are required for a normal child, plus those needs of a child suffering from a cardiac disease. A normal child requires regular rest, fresh air, sunshine, exercise, food, fluids, elimination, cleanliness of body, teeth, hair and nails, and warmth. The child suffering from a heart disease, either in the acute or chronic stages, has these same requirements in varying degrees.

I have placed *rest* first as one of the most essential needs of a child with heart damage. That means the child must be nursed, in bed, with everything in the immediate environment and around the room conducive to rest.

The position of the patient in bed is most important. In the acute stage, the recumbent position may not be the most comfortable. Therefore, the child must have his head elevated, with his back and shoulders well supported, and a frame of some sort at the foot to prevent him from slipping down in the bed. The Gatch frame bed has been found quite satisfactory for this type of patient. The child's shoulders and arms need sup-

port, so for the less acutely ill and chronic patient a special type of movable back and arm rest has been found very helpful. An over-the-bed table is also necessary to facilitate ease of working and eating for the convalescent child.

The child rests best when asleep; thus it is the responsibility of the nurse to see that he has regular periods of sleep and rest during the day, and a long, undisturbed sleep at night. The pulse is taken during the sleeping period at night to determine how well the heart is working with no undue mental, emotional, or physical strain. If the child is having difficulty in resting, due to emotional or physical causes, a mild sedative may need to be given especially to the patients with chorea. Salicylates may be given for joint pains when the cause of heart damage is rheumatic in origin.

The temperature of the room should range between 68°—70° F. and the relative humidity ought to be about 55 per cent. The air should always be fresh, and when possible the child placed out in the open. The patient must not be allowed to contract colds so he is dressed warmly with flannelette gown and bed jacket, and placed between flannelette blankets.

During the acute stage of heart disease, exercise is passive in nature. Everything is done for the child. He is lifted, turned, fed, and washed by the nurse. As progress is noted, the exercise becomes more active.

Food is a most important physical need. It should be served frequently, attractively, and in small amounts. Every effort must be made to make meal time as pleasant as possible so that the digestive process will not be hindered. If solid food cannot be tolerated a liquid diet must be substituted. The child should receive an abundance of fluids unless for some special reason they are restricted. As noted above the nurse feeds him during the acute stage to rest the heart. Food does play such an important part in the building of strong bones and teeth that we should encourage the child to drink plenty of milk especially.

Elimination is an important factor in the comfort and recovery of the patient. Intestinal elimination may be aided by laxatives or enemata when necessary. The output of urine is often measured to regulate the fluid intake as well as to determine the efficiency of the kidneys.

The skin needs special attention. Due to impaired circulation, the skin may break down; thus every effort must be made to prevent pressure sores. The warm, cleansing bath and frequent alcohol rubs refresh the patient and keep the skin in good condition. The teeth must be cleaned regularly, establishing a health habit to be carried into adult life. The hair and nails should receive special attention, and as soon as the child reaches the stage of more independence he can care for these needs himself.

After many weeks of convalescence the child is allowed to resume his place in the home, preferably under the supervision of the public health nurses, who will follow his progress.

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Preview

Health has been included in the school curriculum for a whole generation. We must admit that Mr. Average Citizen is much more health-minded than his forefathers. Yet actual statistics show that there are still countless gaps in his application of health knowledge to his own mode of living. Why? **Rae Chittick,** who has been teaching potential teachers for many years, attempts to determine for us just where our health teaching program fails. Every nurse should be a health teacher, so every nurse will want to read this challenge to the nurse who is engaged primarily in school work.

The Public Health Nurse and the Cardiac Child

DOROTHY A. TITUS

HEART DISEASE in children is perhaps the greatest of their chronic disease problems. Therefore, the role of the public health nurse is a most important one in the prevention of this disease whenever possible.

Since it has been pointed out by Dr. Donovan that 90 per cent of heart disease in the first twenty-five years of life is the result of rheumatic fever, we can realize how great is our responsibility for the prevention of this disease. If we can prevent rheumatic fever or recurrences, we can do much to make it possible for children to live a normal life in place of a crippled existence. We must remember, however, that not all children who have rheumatic fever develop serious heart disease and a large number of children who have rheumatic fever never develop any permanent damage to the heart if properly cared for.

The public health nurse, coming in contact with parents of young children in the home, the school, and in the clinic, has an excellent opportunity to teach. The best way to treat rheumatic fever is to prevent the original attack from taking place by the application of general health measures:

1. Good personal hygiene, plenty of fresh air and sunshine, adequate rest, a wholesome, well-balanced diet.
2. The prevention of infections, principally those of the upper respiratory tract.
3. The importance of sufficient and proper clothing, suitable to the weather.
4. The importance of adequate housing—homes properly heated and ventilated.
5. The importance of noting any unusual signs or symptoms which might be the beginning of rheumatic fever and of bringing them to the attention of the doctor. These signs have been discussed in detail in the previous article.

Two main groups of children that need particular attention are those who have had rheumatic fever but no heart disease and those who have had the heart affected already.

The problem in rheumatic heart disease resembles that of tuberculosis in which, also, we must be constantly on guard for re-activation of the infection. Since recurrences of rheumatic fever are most apt to occur within the first three to five years after an attack, various measures have been advocated to try to prevent such recurrences. A child who has had rheumatic fever, whether or not there is any demonstrable damage to his heart, should be under regular medical supervision. The parents of these children must be made aware of the signs and symptoms to be looked for and anything unusual about the child should be reported to the doctor at once. The general health of the child is of great importance so that he will be able to put up a strong resistance to infection. The general health measures already outlined should be strictly adhered to, rest being particularly important. The child should remain in bed for any cold or sore throat, no matter how slight, until all signs of disease have subsided completely. It is important that he should be seen by a doctor at such a time, as the use of the new chemical drugs may help to prevent an infection which may cause rheumatic recurrence.

In caring for a child with heart disease, whether congenital or acquired, we have much to break down in the many fads, curious superstitions, and collections of misinformation which usually account for so much fear and discomfort in those who have the disease. Children are prevented from sitting, talking, and playing because of these unsupported and senseless precautions. The public health nurse can do much by proper teaching to prevent this misinforma-

tion, and to apprise the general public of the fact that when a child has a heart condition it does not necessarily mean total incapacity, short life, sudden death, and so on. The majority of children, if properly cared for, live long and useful lives. A child whose heart has been damaged needs to have his manner of living regulated so that his heart can be given the best possible chance to function. To determine what restrictions should be placed on the child suffering from heart weakness is the physician's responsibility. When the child is permitted to leave the hospital, the mother must be informed of the great importance of taking the child to the doctor for a regular check-up.

As in other diseases, so it is true in heart disease that the child needs sufficient rest. It is important, therefore, to find out from the physician exactly what kind and how much rest is required; rest should be combined with relaxation. The morale of the child must be taken into consideration and all intense emotional disturbances avoided.

The child's weight is of great importance. Maintaining normal weight is one of the ways in which we may avoid placing a strain on the heart.

Education and Vocation

Children who have damage to the heart during school life need some adjustment of the school program. During the convalescent stage, the doctor may permit the child to carry on some school work if a home teacher is provided or available; if possible, provision should be made for adequate home teaching, so that normal advancement in school will not be interrupted. The change over from regular school instruction to home teaching and back again should be made with as little delay as possible for the child needs the companionship of other children. He must be taught to be independent and every effort really be made to have him rise above his disability and advance in spite of it.

In later years, education in secondary schools should be directed toward training the cardiac child for some vocation that will not necessitate heavy physical labor or working in dampness and dust. Vocational guidance, therefore, becomes of utmost importance. The decison regarding the child's future should be made, however, only in consultation with a physician.

In conclusion, we must not bury heart disease under an avalanche of superstition and ignorance! Proper treatment will take into account the cardiac capacity of the child; proper treatment will impose in detail every one of the necessary restrictions. It is well to bear in mind, however, that heart disease requires careful observation and that, having decided not to apply superstitious notions to the life of a cardiac child, one should proceed to get the best medical advice and follow it carefully. A child must not live in unnecessary darkness and grow up an invalid; on the other hand, it is the purpose of good treatment to broaden the view of the child as much as possible; to make life as normal as his condition permits, and not to deprive him needlessly of any normal activity. Remember that work and self-sufficiency make for dignity and mental health which should not be denied unless it is positively necessary.

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Preview

What do you know about Infectious Mononucleosis? No, we didn't either until we read the very clear explanation written by **Mrs. Helen Morrison.** Incidentally, the University of Alberta Hospital Alumnae Association offered a prize for the best article from among its members for submission to the *Journal*. This is it. Perhaps some of the other alumnae associations might adopt this method of securing worthwhile contributions.

The Nursing Profession and the Evolution of Public Social Services

CHARLOTTE WHITTON, C.B.E.

SOCIAL change is upon us: in fact we are aswirl in its currents. The nurse has two heavy responsibilities, among others, directly facing her: one, her responsibility as an intelligent citizen in a community and social structure in transition; the other as a member of one of the professions most directly affected and challenged. (Perhaps her responsibility merges almost too quickly for though nursing in half a century has become the largest of all the women's professions but teaching, less than half of the 52,000 nurses in the country are active. Matrimonial mortality is high: 4 out of 5 of the nurses leaving their professions in 1939-44 left to be married.)

THE NURSE AS CITIZEN

Any responsible citizen, who would discuss social provisions today, must face honestly the fundamental question of clashing principles as to the very basis of the organization of our society. Decisions cannot longer be begged; today two different philosophies of life and of social organization are being offered to us in Canada. The question each of us must decide is whether we shall continue along the lines of the fundamental principles of opportunity being purchased and assured by responsibility, or whether we shall turn our backs upon these hitherto prevalent principles of social progress in Canada and agree to place all the resources and activities of the people under social control and subject to development and regulation within the administrative will of an overruling state. As we decide on the major premise there will be major variations in our subsequent plans and decisions.

For the purpose of this discussion, let us assume that we are going to attempt to proceed upon some fairly simple and fundamental principles. First I place the conviction that no responsibility and no right can be exercised except as one assumes the corresponding responsibility of a decent task well done. We cannot ask rights and privileges, we cannot ask a share in the reward of decent, honest effort within the state, unless we ourselves are prepared to take our fair share, our fair responsibility in service to our days, to our community, to the state to which our allegiance is given, and to mankind. If, however, we honestly devote ourselves to that part of the community and national task that is ours, if we there discharge our own personal responsibility, well and honorably, then we have the right to ask that the state play the game with us, in fair dealing one to the other. This playing-the-game by the citizen to state and the state to citizen demands that the man or woman who is willing and able to assume his obligation in the building of his day earns the right to certain duties from the state. The state in turn should assure opportunity, opportunity to grow, to have gainful occupation under happy and healthy conditions and with such rewards in fees for skills, salary for services, wages for work, prices for goods, yes, and earnings for savings, as to allow the people to discharge the obligation of maintaining themselves and their dependents, at reasonably decent standards of living. The partnership means not only assurance of this opportunity of livelihood in self-supporting occupations, but protection for all workers in the break-throughs that will come in life.

Some are born well-endowed in physique, in mind, in spirit, in resources; others are born, handicapped or frustrated almost before birth;

some go on to fulness of life and health — a vigorous and satisfying youth, a strong middle-age, a hearty, firm old age; others falter all along the way; others face sickness, breakdown in mind, body, estate, character, the dependency of premature death in their family group, etc. The community and the state must anticipate the occurrence of such exigencies, work for their prevention, and provide for the sharing of their costs. This means, then, that part of the state and the community's obligation to its citizens, providing those citizens are playing the game of honest, decent service to the state, will involve two lines of defence. The first calls for decent community planning, for housing, health, and school and welfare services, all designed to contribute to the better living of life, to equipping the citizen to live his life happily and adequately; the second line will reinforce the community services and opportunities when breakthroughs threaten maintenance.

These duties of citizenship in a democracy demand intelligent, individual study so that each person may be properly informed and equipped to play a responsible part in developing the exact techniques and mechanisms whereby these essential services may be assured — assured first within the capacity of the state to provide, and, second, with intelligent selection of the order of priority in their provision.

National Capacity and Welfare Priorities

For instance, Canada's national income, swollen by war costs, taxes and exports, can hardly be sustained, at best, at a higher figure than a billion to a billion and a quarter dollars per year for each million gainfully occupied workers. This would place our most sanguine postwar income now at perhaps not more than six billion dollars. Roughly two-thirds of a people's income is required for their mere physical maintenance, food, clothing, shelter, etc., leaving Canada, under any system of exchange or currency, about one-third, or two billions, of her income for all the purposes of national living, public works, education, welfare, etc. Obviously, she must choose the value and priority of the social services she will select and carry. Any other course offers social bankruptcy, not security.

Our first priority, it would seem, should be a logical liability for the maintenance and bringing up to standard of the social services Canada has already assumed, particularly in education, health, care of children, and the aged. These may be grouped in three major categories.

Social Utilities, Insurance, and Assistance

The Social Utilities: This category includes the services so essential to the well-being of the individual and of the community as a whole that we simply cannot leave them to chance; we must plan for them through co-operative community effort. They are the needs that we agree it is much better and much cheaper, in every way, to provide from the resources of all, regardless of the income of any, than to leave to the responsibility of individual citizens, no matter what their income.

The outstanding Canadian social utility is education at the public cost. Seventy-five years ago, in Upper Canada, education of one's children was one's personal reponsibility, and the provision of that education was largely a matter of private enterprise from a private professional staff. Then it was decided that this was not in the interest of a well-informed, vigorous citizen body, and so, in 1870, Ontario sought to make such measure of public education, as she could provide within her resources of funds, of personnel and of transport, a *social utility*. Four months' schooling was assured each year for all children from 7 to 12 years. That was the precursor of one of the finest systems of public education in the world today, which extends from preschool services through to the university and, in fact, though the universities still remain partly pay institutions,

public grants make part of their services, at least, available as a social utility. We have used this utility principle in sanitation and, in increasing degree, in public health, in the cure of tuberculosis, and, in some of the provinces, in the care of cancer. In one of the provinces this year, special maternity care has been placed on this basis. The *Social Utilities* are the first and natural line of a community's social provision, historically and in fact.

The second and third categories, in historic order, are *Social Assistance and Social Insurance.* But for discussion purposes it is possibly simpler to take *Social Insurance* first. Within the last sixty years, it became possible, through actuarial ingenuity, to apply the principle of private commercial life and risk insurance to the underwriting of certain social hazards, and so social insurance came into the picture of the welfare defences. *Social insurance,* in *principle,* does not differ from commercial insurance. It substitutes the state, and sometimes the employer, for private enterprise in administration and supervision and, of course, takes in the contribution of public funds along with personal premium payments. Insurance, however, has very definite limitations as a social device *if it is to be sound and safe for the community and citizen alike.* If any program is based on insurance, it is obvious that there must be something to insure; in other words, there must be income. It is not possible to provide, at any rate of premium under a system that is true insurance, for benefits which will yield to a person, not engaged in gainful occupation over an indefinite period of time, funds proportionate to what he would receive or, in some cases, greater than what he would receive at his gainful occupation. Also, the benefits must be related to the amounts paid as premiums and to the duration of those payments as in any sound insurance practice. Now, all this raises tremendous difficulties in attempting to use insurance for a wide range of social protection in Canada, because our climatic and geographic conditions are such that many of our basic activities which are essential in the national wealth are subject to tremendous, natural, seasonal slacks.

For instance, agriculture, lumbering in the greater part of the country, fishing, construction work, shipping, many an activity of which you will think, have, normally, a short working year, with the result that, of all persons engaged in gainful occupation in Canada, about one in five has not a longer working year than thirty weeks. Obviously, you cannot carry an economy providing by insurance for several weeks of idleness every year when that is a normal condition. The new British social insurance scheme is tied to a 50-week working year.

Moreover, social insurance not only assumes continuity of work but a payroll deduction by both employer and employee. Here, another difficulty arises in Canada. Ours is not wholly an economy of wage workers. Over a third of the Canadian population are "own" workers; this is particularly true of our agriculture. It is true of every little town and village, and even the large cities, in respect to a great number of those in our shops and other small enterprises. The doctor, the nurse, many a professional group "work on their own." In large groups of our workers, the sharing of reward is on the basis of living allowances, provision of goods, etc., as with the hired man and his family on the farm, and not on an easily assessed cash basis susceptible to fixed insurance deductions and collections. Therefore, in Canada, if we are going to try to carry the protection of our people through social insurance, there will be large numbers, even in insurance, as in unemployment insurance today, for whom the benefit is not adequate enough, either in length of time or in amount, to provide for all their needs when idle, because it has to be related to the length of time worked and remuneration when working. Then there will be large numbers in non-insurable groups, and even in indus-

tries which we insure, who will be left out.

So, in Canada, even with such measures of Social Insurance as we may adopt, we shall have to have something else not so much as an auxiliary as for basic underpinning of the whole structures. *Social Assistance* is the practical answer.

Social Assistance, unlike Social Insurance, is as old as Christianity itself. It evolved in the alms of the early church, was modernized first in the Elizabethan Poor Laws of England, and crossed to this continent with other British institutions. Improving in technique, concept and humanity, it has extended into the special categories of Old Age and Mothers' Allowances, Unemployment and Social Assistance. It is described by Beveridge as a necessary pillar beside Social Insurance.

Of these two categories we have but one form of Social Insurance, unemployment insurance, in Canada, and diversified and ill-integrated Social Assistance. Old age, Mothers', family and unemployment allowances are all in a highly unsatisfactory and contentious melee of financial and administrative responsibility. There are two or three different authorities involved in their administration and, nowhere, have we yet worked out a thoroughly well-correlated system of integrated social assistance, though British Columbia has gone far to this ideal in recent months. *Social Assistance* simply means that a state and its communities will provide that need will be prevented, of course, as far as possible, but that when it does arise, from any cause, it will be dealt with at once wherever it arises. Assistance must be flexible and given in service, in cash, or in kind, i.e., in shelter, in fuel, in clothing, in food, or in whatever form the circumstances suggest, as long as the need exists and along such lines as to contribute to placing the individual upon a self-supporting basis again. If, as in the case of disability or age or the like, that is not possible, then *Assistance* should be certain enough and permanent enough to guarantee that the individual does not suffer and that the state discharges its obligation with justice, both to its dependents and to the citizen body at large.

The problem immediately before Canadians now is to ascertain what the social problems are that arise within the Canadian population; which one of the three methods or techniques will be best to apply to each, in what priority we should plan their provision, and what portion of our resources we can safely deflect to the whole program and to each part thereof.

The nurse as a nurse will have a very definite and vital part to play in all these areas of social protection, particularly in the *Utilities*. For, by whatever means our services are provided, there is, all along the line, the health of the individual and the health of the community to be considered. So the nurse will be prepared, if she be a forward-looking member of her profession, to attempt to visualize herself and her professional place integrated into the state's development of *Social Utilities, Social Assistance, and Social Insurance.*

So much, then, for the Nurse as Citizen in the day of social change. What of the nurse as a member of a healing profession faced with the *health care of the people?*

The Nurse as a Nurse

Six areas of Health Service: There are, it seems to me, six spokes in the wheel of health progress today. These are (1) *Public Health* in the broadest possible sense of preventive health services, extending out from sanitation, the control of communicable disease, industrial hygiene, housing and, in fact, all community planning conducive to good health, both physical and mental. Preventive medicine merges into (2) the provision of *Actual Medical Services* to assure diagnosis that is early, adequate, and complete, including laboratory facilities. (3) Leading out from the actual medical or clinical services, there will be *Hospital Services*, general and specialized. The

latter will include, as today, care of the mentally ill and the tuberculous; convalescent and specialized units. It is a moot question whether the services in the borderland of hospitalization, such as care of the infirm aged, the chronically ill, etc., should be assigned as part of the health services or fit into the round of welfare and custodial care generally.

These major needs of public health, diagnostic and medical care, and hospitalization centre in with three more: (4) *Nursing Services;* (5) *Dental Services;* (6) *Pharmaceutical, Optical, Surgical* and like requisites.

Looking at these six areas of requisite service in the health care of the people, in a country as extensive, sparsely settled, and subject to wide climatic and geographic differentials as ours, it would appear that all these services call for provision on the basis of a *Social Utility*, unless perhaps hospitalization, which, being centred within special units of care, might be submitted to a participating prepayment insurance plan.

Our Nursing Needs: Examining the exact nature of the services to be given, one sees at once that nursing differs somewhat from all the others in that it is shot through all of them, varying with the function and work of the nurse concerned. Moreover, the entire program of more adequate health care for the Canadian people may well turn upon the rate at which adequate and efficient nursing personnel can be provided. The training of medical personnel is very costly, the provision of hospital facilities still more costly, the creation of diagnostic centres comparably so, but a great part of the preventive, educational, and actual care program can move forward with comparatively low cost as public health and bedside nursing can be extended, particularly in rural areas.

If we accept assurance of *Adequate Nursing Personnel* as very high in the requisites to any safe and sound expansion of health services for Canada, it would seem a natural next step to ascertain what the nursing supply is, what the exact demands of extended service imply, and how these might be best met. The most comprehensive recent data would appear to be that made available by the special war procurement and allocation studies of National Selective Service. Of approximately 23,000 nurses active in their profession — excluding those in military nursing — nearly half were in the hospitals and training schools, 15 per cent in public and preventive health services (including the V.O.N.), about 30 per cent in private duty, and the remaining 6 to 7 per cent in various other professional fields, several of these in welfare services. These facts reveal significant trends in the period since the Weir Report when fully 65 per cent of all nurses were in private duty, as compared with less than a third today. Modern living conditions increasingly shift care of the sick to hospitals, the five years from 1939 to 1944 marking a 10 per cent increase in the latter with a corresponding increase of 10 per cent in the nursing supervisory and 18 per cent increase in the general duty staff of hospitals.

There would seem to be some clear indications of the nature of the nursing services and the relative demand for them in the changing and extending provisions of health care in Canada. (1) Certainly the nurse is vital in *the educational and preventive aspects* of the developing public health program. (2) As this inevitably shifts into enlarging diagnostic and preliminary treatment phases, *more nursing staff, with clinical experience*, will be required for senior responsibilities in the health centres. (3) These health centres, especially in rural areas, will inevitably spread out from or extend into hospital facilities, merging nursing responsibilities over administrative, supervisory and clinical duties. (4) Preventive, clinical, hospital, and convalescent specialization will tend to reduce the length and "intensity", as it were, of the patient's need of a personal duty nurse in the private home, causing, in all probability, a shift in bedside nursing in the home from a

daily to an hourly, and so from a "private enterprise" to a community basis. (5) Inevitably, private bedside work on an individual basis will shrink to where possibly not more than 7½ to 10 per cent of the nursing personnel of Canada will be so engaged.

Meanwhile, the "shaking down", as it might be called, of the whole range of Social Assistance and Insurance, and the greater co-ordination of health services will probably operate to "de-hospitalize" the very large number of convalescent, aged, infirm, and chronic patients now occupying costly hospital beds. They will pass for care into smaller local hostels in the less populous areas and into special units or blocs in the larger centres. The impact on nursing needs will be the same — highly concentrated skilled nursing of the really ill in hospitals, experienced supervisory staff in these semi-invalid hostels, and more "aides" of lesser skills, as auxiliary help in both types of institution, a development evident in the increase of some 50 per cent in ward aides 1939-44.

Does Nursing Face Drastic Changes? All these trends would seem to present the nursing profession with an almost inevitable change — a rapid shift-over from a profession of individual enterprise on a fee basis between nurse and patient to one of full-time staff status, under contract with the institution, community, or community agency.

Better health care for Canadians will advance or slacken in very large part as these various areas of essential nursing needs are met or left unserved. Their inadequate serving would seem to call for the greatest reorientation in outlook upon the nursing of the sick that the profession has faced since the revolution of Florence Nightingale's day. This time, the community and general public are also vitally concerned in the basis and nature of the integration, undoubtedly indicated, of educational training, preventive, bedside, and administrative nursing. Where does the answer rest? Is it in the socialization of the profession? Hardly, for perhaps no factor in the care of the sick is so essential to the comfort, happiness, and peace of mind of the patient as compatibility as well as efficiency in nursing attendance. Yet there seems to be a general tendency in present social health plans blithely to include nursing, along with drugs, dentures, and appliances, as something which can be set out as a simple per capita item and carried, rather inconsequentially, into the overhead costs of any prepayment or so-called "insurance" plan for the health of the Canadian people. In fact, one successful co-operative venture paid out recently over $63,000 for medical, $21,000 for hospital, and less than $1,000 for nursing costs over a period of time. Of course, so long as the net earnings of the average Canadian physician and surgeon are $3,142, of the dentist $2,032, of the optician $1,771 and of the graduate nurse $1,009, such major disparities will exist in any co-operative underwriting of health costs but they should not be greater than they are!

The challenges presented are far-reaching and fundamental. They extend over the whole gamut of nursing from probable drastic recasting of training to new community approaches in the concept of nursing service itself. The numbers, the quality, and diversity of experience, which will be required in the nursing personnel of any broad social health program, make the question of nursing training and education as vital, urgent, and significant an aspect of any advance as the organization and financing of any such schemes themselves. The nursing profession is itself well aware of this but few of our legislators or of the general public seem seized of its importance. Nursing, no more than medicine or dentistry, can meet the demands facing it with nursing education suspended part way between the area of training and that of less-than-cost provision of probationer auxiliary help in hospital operation. There seems little doubt that any

plans for carrying more and better health care to the Canadian people will bog down if they do not recognize that a large and first part of their program must begin right here in a long over-due grappling with the problem of nurse education and training for nursing service.

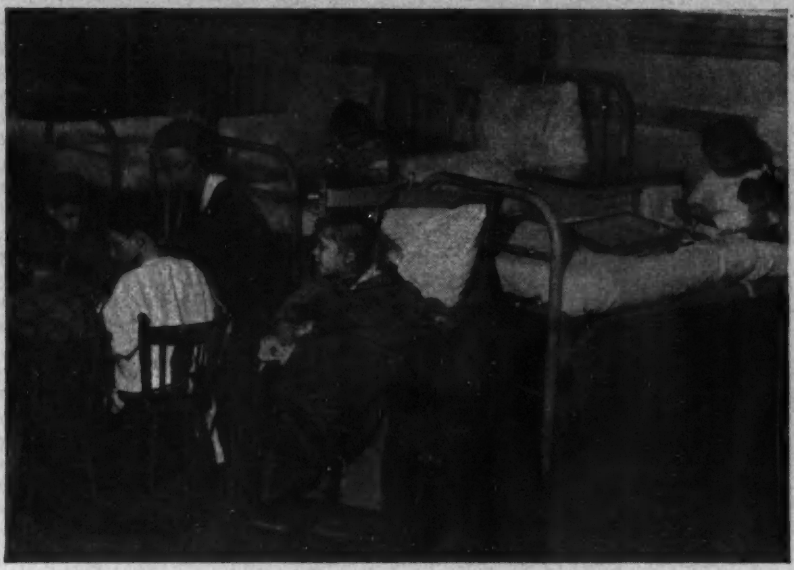
And, secondly, nursing is so essential to our ability to carry a broad health program in this country that more intensive study must be given, before its inception, to the pattern by which nursing will be organized and made available to the individual community and patient. Will the answer lie in one generalized nursing unit with specialized staff in each area? Should we not be attempting some experiments in selected centres, urban, town, and rural? Would it be practicable to try out some such ventures under local Boards of Nursing Services, composed of representatives of the healing professions and lay citizens, selected for their knowledge and association with public health, hospital, bedside, and private nursing services? In each centre, chosen for trial, let the nursing challenge be faced as a whole, and the nursing resources of the community assessed as a whole, with respective spheres of specialized service and supervision therein then assigned to the specific groups best qualified to deal with each. The public health authorities could continue, as at present, operation of the preventive program and the hospitals assume bedside care for their patients and afford facilities for practical teaching. The V.O.N., or comparable visiting nursing unit, could carry the bedside program in the home. The demonstration unit could have special provision for registration and allocation of the patient and nurse, desiring private duty service. Let the nursing personnel be dealt with as a unit, retained on a full-time basis of equitable remuneration, regardless of specific duty, though based, of course, on seniority and qualification, and let the nurses rotate from preventive to treatment, from community to institutional and home care. And let the whole experiment be under the most competent observation and measurement. Then, and on the basis of such proven data, Canadians would have before them results on which they ultimately may make progress more surely than in our present reliance on theoretical overall schemes of broad concept but little certainty in execution.

At least this is as it all looks to a lay woman whose privilege it has been to work closely for a quarter century with many of the leaders of Canadian nursing whose character, dignity, and worth have placed their profession in foremost rank in world nursing today.

Busy Hands — Better Health

BARBARA MILLER

AT THE Children's Memorial Hospital in Montreal the words "Occupational and Recreational Therapy Department" do not mean a thing to its little patients but they do know what the ladies mean who come to their wards every day, wearing green uniforms and pushing a carrier filled with toys and games and things to make. They greet us with the words, "Oh! Here she comes. Let's play something." The vacant little faces brighten visibly and happy little cries ring through the ward as they lean almost out of their beds to choose something special for themselves, long before the carrier ever reaches their bedside. Mary, aged 5, just loves doing jigsaw puzzles — the Walt Disney kind with about six large



Concentrating on the game

pieces to fit together; Don and George, aged 8 and 9, like having their beds pushed together so they can play Steeplechase; Jeanine, aged 7, gets a big thrill out of the five little Dionne dolls with all the different outfits they each own; little Betty chats away by the hour with her Mommy and Daddy on the little toy telephone that has a real "ring" and even a voice in the earphone to answer her back! Young Jacques, aged 4, learns about the farmyard as he plays with the delightful little metal animals that will fit into a big barn. Little Shirley, aged 11, with her eyes all bandaged, loves the "feel" of the soft furry puppy she is given to hold.

All too soon the hour is up and the "green lady" collects all her toys and wheels them away until the next time. Perhaps the next time the children will note with dismay that she has come empty-handed. Dismay soon changes to giggles and laughter when out of her mind she pops all sorts of games.

The smallest children are arranged in one circle and the older ones in another with the beds as close together as possible, without disrupting the ward too much. Sometimes a few children are allowed to get up in their dressing gowns and sit around a table — and then the fun starts again. "Let's play 'Twenty Questions' " — then, "How about 'Button, Button'?" Then, "Do you remember how to play 'Knocking'?" "Now let's finish up with some songs — 'Old MacDonald had a Farm' or 'Frère Jacques.' "

Once more the morning whizzes by and it is time to restore the ward again and say goodbye to the "green lady" as she returns to that mysterious place called the occupational and recreational therapy department. As soon as John is able to be up and around on the ward, the mystery of that place is solved for him, because he is sent there himself every morning and afternoon. It is in a separate building, halfway up a little hill behind the main hospital. It looks so cozy, settled in among the trees with a long verandah right across the front, giving a view as far as the St. Lawrence River. As soon as he steps inside, it looks so gay! Games and toys of every kind and color are arranged on open shelves on

two sides of the room. Gaily colored ducks mark the division of the games into age groups. Just about everything else he sees is painted pale blue and pink. Even the piano is pale blue with pink trim and beside it is a little pink pump organ! Two lovely big doll houses with every kind of furniture, right down to a toy vacuum cleaner, are along one wall. Windows along two walls and French doors along one complete wall let in lots of light and create a cheery atmosphere. After the first, "Gee, this is swell" and "Where d'ja get all the toys 'n games?" John settles down to learn some craft work. There are so many things he may choose from he finds it hard to make up his mind. It helps a bit to show him something that other children have made. There are leather key cases, wallets, photofolders and pencil cases; there are cardwoven bookmarks and belts; there are plastic paper knives and jewelry; there are woolly sheepskin puppies; there are all sorts of hooked articles; there are scrapbooks and photo albums. After a little deliberation, it is decided that John should start on a little key case, because it will be simple for his first project. Several other children ranging in ages from five to fourteen are busily engaged in making various articles. Some of them are children from the medical and surgical wards like John, some from the cardiac ward, some from the orthopedic ward, and some from the out-patient department. Any little children under five, who are able to come to the occupational therapy department, spend the hour in some form of play — either individual or group.

The children on the cardiac and orthopedic wards receive the most attention from the "green ladies" because they have been, and will likely be, in hospital for so many months and even years. The cardiac children receive specific occupational therapy in the form of graded occupations, according to the degree of their illness, as indicated on the physician's prescription. These range from complete bed-rest patients being given small, light, scrapbooks or cards to look at, to semi-reclining patients doing sim-

A busy morning in the O.T. department

ple jigsaw puzzles; to sitting up in bed doing very light craft work, such as sewing, to heavier craft work, such as leatherwork; to sitting up in a chair doing craft work; to the complete ambulatory stage, when they are able to come directly to the out-patient department every day.

The orthopedic children receive specific occupations whenever possible, either on their ward or in the occupational therapy department, if it is possible to move them. Some children in hip casts are carried over to the occupational therapy department every day for their period of craft work in the morning and play in the afternoon. It does them a world of good to get them away from the small environment of their own wards and to get a daily peek at the interesting activities in the occupational therapy department.

Coming daily to the occupational therapy department is particularly good for the children from the cardiac and orthopedic wards, because they are meeting new and different children almost every day. It is good for them to learn to work and play together happily, with the little strangers from other wards who only stay in hospital perhaps a few days or weeks.

Quite frequently, children are referred to the occupational therapy department from the out-patient department to receive some specific therapy. These children come two or three times a week for a period of two weeks, after which time they return to the clinic and their progress is noted on an occupational therapy report. After the re-examination they may or may not have to continue coming for treatments.

One branch of the occupational and recreational therapy department, which is progressing very favorably, is that of music appreciation. The children on the cardiac and orthopedic wards each receive one afternoon a week of this instructive and absorbing entertainment. With the aid of a portable electric phonograph, a new world is opened out to these children. "Peter and the Wolf", "Pinocchio", "Snow White", "The Green-Eyed Dragon", "Alice in Wonderland", "The Nutcracker Suite", "The Blue Danube", and many, many other delightful characters and melodies gradually become familiar, as they are repeated from time to time. Just lately a special sort of pleasure has been discovered by the children in the fact that they too can make music of a sort — at least they can keep in rhythm! Our new rhythm bands are a delight to all.

Occasionally there is an opportunity to help a child along with playing the piano. If he knows anything at all about it, he can practise on the pretty blue piano in the occupational therapy department. If he doesn't know a note, but would like to learn, he is taught if it is at all possible for him to come to the department.

"Special" days, such as Christmas, Valentine's Day, Easter, and so on, are occasions for great excitement on all the wards. Several days ahead, symbolic decorations in appropriate colors are made and arranged on the windows and walls of every ward. When the great day arrives, its afternoon is a gay whirl of party favors, favorite games, and songs. Tired but happy, the children are ready for sleep soon after their supper, which in itself is usually something "special" on those days.

Every new day presents its joys and its problems, in this very active branch of the Children's Memorial Hospital —but we love it. We strive to make our hospital a place for fun and happiness, a place where an interesting game or craft can be adapted by the occupational therapist to help straighten out any deformities or stiff joints, a place where little Henry can forget that awful ache in his stomach, and the bigger ache in his heart as he thinks about home. It gives one a special sort of thrill to hear a child say, "Gee, this is an awfully nice hospital. I like it here."

There is nothing so easy but that it becomes difficult when you do it with reluctance.

Terence, 159 B.C.

The Treatment of Infantile Paralysis Based on the Kenny Conception

ELEANOR BRIDGES

POLIOMYELITIS is an acute infectious disease caused by a filterable virus. It is an infective organism not cultivable by bacteriological methods. The organism enters the body by means of the nose and throat, and travels along the central nervous system and nerve sheaths. As the nerves of the central nervous system are not myelinated, regeneration is not in evidence, thus making the paralysis caused by the organism permanent if the organism entirely destroys the nerve.

There are inflammatory changes about the blood vessels and degenerative changes in the nerve cell and gray matter of the spinal cord and brain. There is also inflammation around the meninges. The lesion in the brain is always present and the disease ensues whether there are any lesions in the cord or not. When the spinal cord is affected, the muscles that appear to be in spasm bear a relation to the level of the cord lesions. If the brain stem is involved there may be signs of encephalitis with paralysis affecting the face, eyes, and tongue. The paralysis lasts only a few weeks and then there is tenderness and wasting of the muscles.

Sister Kenny's conception of poliomyelitis is that the muscles diseased are in spasm, and thus classes the condition as a form of spastic paralysis. The flaccid paralysis is the secondary result of the spastic paralysis. The pain and tenderness is caused by the spasm in the muscle and the muscle in spasm is shortened. It is not necessarily the whole muscle that is in spasm — it may only be a few fibres. By efforts to stretch the muscle the spasm is increased.

The spasm is detected by the inability of the muscle to stretch to its full extent. Thus passive movements of the muscle or groups of muscles is the method used for detecting spasm. Stretching, too, causes pain and there is also definite tenderness.

SYMPTOMS

Alienation: The flaccid paralysis is mainly functional. The fear of causing pain by stretching the muscles in spasm, when the antagonistic muscles contract, makes the patient try to protect these from being stretched and thus he refrains from using them. There is a functional break between the brain and the muscle and the patient appears to have forgotten how to use these muscles — thus they become alienated from the brain control.

Inco-ordination: There are also many scattered impulses. There is lack of co-ordination between the flexion of one group of muscles and the corresponding relaxation of their antagonistic group. There is also muscle substitution because of the pain caused in using the antagonistic muscle. Therefore, other muscles are substituted in attempting to accomplish a similar movement.

Other symptoms: The average duration of the acute stage, as measured by temperature and subjective symptoms, is five days. It seems to start with a headache, usually in the frontal portion, which lasts for approximately two days and is intermittent during this time. Any jolting or sudden movement increases the pain. There is usually very severe pain found in the neck, back, and limbs, and the first day a moderate amount of vomiting occurs. The temperature is elevated and the patient has chills and sweats which are common with a fever. The throat is sore, or appears to be sore on swallowing, but this is usually due to the neck muscles being in spasm. Speech and swallowing are often interfered with because the neck

muscles are affected. There is sometimes diarrhea which lasts only a few days. The patient is fairly alert, but seems more sensitive, irritable, and restless. Sometimes the vision is blurred or there is double vision. On the third or fourth day the temperature may be elevated slightly higher, signifying that the disease is spreading to the cord. Paralysis now manifests itself.

From the records it appears that the disease occurs most commonly in persons of about twelve years of age and in the male slightly more frequently than in the female sex. It usually occurs during warmer weather and reaches its climax during the month of September. When a spinal puncture is done, it is frequently found that those with a moderately elevated cell count have symptoms of the disease. This is not so in every case.

Prevention

Flies should be kept under control as much as possible. The urine, stools, and secretions from the mouth and nose should be disposed of with care as this is where the virus is found. Children should be prohibited from bathing in pools in the hot weather. Tonsillectomy and adenoid operations should be suspended during an epidemic.

Treatment

The object of the whole treatment is relaxation and re-education. Rest in bed curtails the acute stage to a certain extent and immediate treatment is necessary. After the physician or the physiotherapist has located the spasm, the application of hot fomentations is started immediately. To obtain the full benefit of these fomentations, there are a few basic principles that must be observed:

The bed: A fracture board is placed beneath the mattress. A wide piece of wall-board is placed vertically between the foot of the bed and the mattress and tied securely to the frame of the bed. Two four-inch blocks of wood are placed between the board and the foot of the mattress near the outer corners of the latter to leave a gutter for the patient's heels.

The patient lies between two woollen blankets but with a cotton draw-sheet under the head and another under the buttocks. The bed-clothes covering the patient are carried over the foot board. This board serves to maintain the normal standing reflexes through contact of the sole of the foot with a plane surface and to keep the weight of the clothes off of the feet. In very small children a box is substituted for the foot board. The feet are not kept against the foot board if spasm is present in the calf muscle. The blankets are used because the sheets are likely to feel cold and would only accentuate the spasm.

Position in bed: Have the patient lie in a normal anatomical position without any form of fixation that might lead to rigidity or stiffness of the joints or tightness of affected muscles. For relaxation, the patient should be turned on his face two or three times during the twenty-four hours. No harm may be done through voluntary movement. The patient lies with no restraining apparatus so that relaxation of the muscles is possible.

Fomentations: The Kenny treatment deals with the relaxation of the muscle in spasm and is definitely averse to the idea of stretching a paralyzed muscle. Nature gives the symptom of pain to us as a warning and this is not to be taken lightly. If we, therefore, subject the patient to more pain by stretching the muscle, we are undoing nature's way of protecting and giving aid to a sick part of the body. By means of applying hot fomentations and allowing them to cool the idea of stretching the muscle is really being carried out, but it is not the painful operation it was previously. The heat of the fomentation relaxes the muscle fibres and, as it cools, contracts them. In this way the fibres do not lose their ability to stretch and contract.

These fomentations are made from white wool blankets and are of double

thickness. For the back, abdomen, and neck, rectangular ones are used. For the limbs, shoulders, and buttocks, triangular ones are used. These different shapes fit better and allow free movement of the part where the fomentation is applied.

They are boiled in a boiler, put through a wringer, and then carried to the patient's bedside in a square of rubber. The fomentation is quickly applied, followed by pieces of Venetian cloth and dry flannel which have been cut in the same shapes as the fomentation, only a little larger. Cotton binders and safety pins are used to keep these fomentations in place.

The fomentations are applied during the day and as frequently as possible during the acute stage. In the chronic stage they are changed once every one or two hours. The application of the hot, moist fomentations seems to stimulate the skin and keeps it healthy. There is little or no trouble caused from rashes or breaks in the skin.

Re-education: It was thought formerly that complete rest was the most satisfactory treatment. No unnecessary examination was thought to be needed. Injections of blood, obtained from an immune person, were given to the patient. Strict medical asepsis was observed and the paralyzed limb was immobilized by means of pillows, sandbags, splints, or casts for three or four weeks. After this length of time, passive motion, massage, and, finally, attempts at active movement were made.

In Nurse Kenny's method, the physiotherapist plays a leading role. First, she locates the spasm and then undertakes the muscle re-education program after the spasm has been relaxed sufficiently. The main idea is to get the patient aware of the muscle and stimulate the normal reflexes of it. The patient's attention should be fixed on moving that muscle. Passive movements of muscle and joints stimulate the muscle to move. Inco-ordination must be corrected by slow movements and repeated exercises. Substitution is prevented by keeping the healthy muscles relaxed while attempting to use the paralyzed ones.

The proof of the effectiveness of the Kenny Method is the fact that there are no deformities. Although immediate treatment is essential to cure the disease, many remarkable improvements have also been made in cases of fairly long duration. The Kenny Method may not be flawless according to many orthopedic doctors, but until some method is discovered other than that being used, such as casts and splints, the Kenny Method, with its amazing results, is definitely our choice of method at the present time.

M.L.I.C. Nursing Service

The following are recent changes occurring in the Nursing Service of the Metropolitan Life Insurance Company:

Appointments: *Jeanne Brais* (Montreal General Hospital), *Emilienne Dion* (Hôpital de l'Enfant Jésus, Quebec City, and University of Montreal public health course), *Fernande Duclos*, (St. Sacrement Hospital, Quebec City), *Antoinette Richard* (Hôpital St. François d'Assise, Quebec City) to the Montreal staff.

Rita Chamberland (St. Sacrement Hospital, Quebec City) has been granted leave of absence from the Quebec City staff, with a Company scholarship, to take the public health course at the University of Montreal. *Mariette Leger* (Notre Dame Hospital, Montreal), of the Montreal staff, has also been granted leave of absence on a Company scholarship to take the same course.

Preview

Current unrest among workers is usually attributed to dissatisfaction with existing working conditions, hours, salaries, etc. These various factors may be lumped under a common heading — personnel practices. Very few hospitals or public health agencies have had well-defined policies regarding their nursing personnel until comparatively recently. **Dr. Frances O. Triggs,** an eminent authority on such practices, has developed this topic as it relates to the nursing profession.

Contributed by Hospital and School of Nursing Section of the C. N. A.

Preparing the Nurse for Present Day Responsibilities

HAZEL B. KEELER

MY TOPIC may be divided into four parts: (1) A brief look at some salient aspects of the present day which have a bearing and should be considered in planning nurse preparation. (2) A few of the attitudes which are so basic to us as nurses. (3) Some discussion of the school of nursing of the present day. (4) Some of the adjustments which must be made in order adequately to meet our responsibilities both in the present and the future.

THE PRESENT DAY

The war did not end leaving Canada particularly affluent. People are very conscious of dollars and cents — they are very conscious of what is not economically sound. They are interested in *speed* — and time is money to them.

Democracy has been dramatized for us since 1939. Before that time we took it for granted. Not since the period of 1840-67 has it meant as much to the average citizen. We see examples of the sensitivity of people everywhere to their rights and privileges as citizens in a democratic society. We see it in the citizenship bill, the choosing of a Canadian flag, the proposal of a bill of rights, in the strikes and threats of strikes. We see it in our own profession, in our talk of collective bargaining, in our proposed incorporation of the national organization. We hear it in the conversation of students and graduates; hours of work, salaries, what they will and will not do — the individual is not to be taken for granted any longer.

Concurrent with these factors, we see a more general concern for group welfare—the older age group, through talk of increased old age pensions and homes for the aged; children, concern for whom was tangibly expressed in terms of the family allowances. We have hospitalization plans, medical care schemes, free care for certain diseases and conditions, provincial plans for vital health and welfare services.

Very evident, too, is a decided and sincere interest in education — both of children and of adults. Real attempts are being made in the provinces toward the equalization of educational opportunity. Great stress is being laid on having an education. Cultural education is being greatly favored by many of the professions and great value is being placed on a university degree for the degree's sake. Tremendous strides are being made in the development of the social sciences — particularly psychology and sociology. Much emphasis is being placed on individual differences, on how people act and react and on how they learn. The average citizen listens to the radio, reads the paper and current magazines and from these sources, as well as from many others, has acquired some knowledge of basic health

principles. It is probable that the citizen of today has as much knowledge of basic health principles as the nurse of fifty years ago.

Present-day Schools of Nursing

Schools of nursing function today in communities made up of citizens, stirring with these ideas, and they bristle with problems as a result. Let us now look more closely at nursing as it is. Nursing is a part of the socio-economic life of the country. Tangible recognition of this was seen in the Dominion wartime money grants to nursing. Those grants taught us the magic of money. We found out that we could do things because we had it.

By far the greatest number of our schools are hospital schools of nursing and most of our students are high school graduates only. The typical school of nursing has students who are immature and yet who are taught under a highly technical curriculum. When they graduate, the public expects truly professional behavior and a high level of maturity. They expect the nurse to have an understanding of social and behavior problems. They expect her to understand normal behavior. Perhaps we need a changed pattern of preparation in order to live up to what is expected of us.

In the typical school of nursing, the student spends most of her time giving service in return for her education. There is no state support, as such, for the school of nursing. State support for nursing education has been going on for some time through some of the universities but our legislatures do not expect to give much money for nursing education, due to our old, bad pattern of giving service in return for our education. The student today pays in service and no accounting is made. Compared to the amount of money made available for other professions, such as medicine, law, engineering, what is received by nursing schools is negligible.

In the United States, there are 13,000 schools of nursing. An eminent American nurse told us that there were not enough well qualified persons to go around for the necessary faculty, with their present set-up. There are 180 schools of nursing in Canada. We have had extreme difficulty in obtaining teaching and supervisory personnel for the past six years, with or without adequate preparation. If there were fewer schools all could have better prepared faculty, including, head nurses (who are of vital importance in student preparation).

Bursaries for post-graduate study are excellent things and are highly desirable. There should be adequate numbers of bursaries available, each of sufficient amount to be truly helpful. *But* they should be allotted most carefully having in mind these questions. Does the profession have need for that nurse? Will that nurse profit from the university experience? If the answers are yes, then award the bursary, other factors being considered of course.

Another point is that in nursing we are tending to progress away from the patient. The route to success seems to be away from the actual practice of nursing. Prestige tends to be attached to supervision and to teaching and not to working *with* the patients. This is not true in medicine and in many other professions and for a monetary reason. In the medical profession, the professor and the hospital administrator do not receive as much remuneration as the general practitioner. The position of the head nurse in the education of the student is basic and fundamental. Patching in the post-graduate period to make up deficiencies in the basic preparation is wasteful and not too successful. We need to lay more stress on the value of the contribution of the head nurse in the basic program. Clinical teachers are not the only answer. We need better qualified head nurses.

The Attitude of Nurses

Let us turn now to a consideration of the attitudes which we, as nurses, must have if we are to face up to the present situation and build wisely for the future. We may have all the modern facilities and the modern techniques and even a fine, well-balanced curriculum but they will be of little

avail unless we have the proper attitudes. Indeed, the attitudes which we have determine what form these facilities, techniques, and curricula will take:

1. The patient is the *raison d'être* of the hospital. Therefore, the hospital cannot exist primarily for the personnel or for the students. Hospitals include in their activity the education of various kinds of students. The aim in educating these students is so that they will become more and more adequate to meet the needs of the patients and of the community. Teaching and supervisory practices, then, should revolve around the best care of the patient.

2. The school of nursing exists for the students and the various policies and practices of the school should revolve around education. Let me repeat—the hospital's first responsibility is to its patients; the school's first responsibility is to its students. The question is thus posed for the hospital school of nursing — how to resolve these two responsibilities under the same administrative framework and within the same overall budget. The school *does* provide care to patients in the process of educating the student but still it exists for the student who must in turn become more and more adequate to meet the needs of *selected* patients — not necessarily all.

3. The attitudes derived from our democratic social philosophy are of paramount importance in nursing today. The democratic processes of planning together, sharing, evaluating, deciding, etc., must become a part of our policies and practices. Because of the wartime emergencies which obtained throughout the country in our hospitals and within the military nursing set-up, we have within the profession many people who have been giving orders and more who have been receiving orders. We may expect an influx of the authoritative and directive type of administation. We must work hard, therefore, to maintain our democratic procedures — where workers present their problems and work out the answers co-operatively. Self-evaluation too should be encouraged. The good life should be attainable by all people and nurses are people.

4. Our attitude toward human resources should be carefully thought through. In Canada we have not used our human resources to the best advantage. The cost of nursing education cannot be separated from the cost of nursing service and nursing service can hardly be separated from the cost of the room. Patients expect the nurse to go with the room though medicines and the doctor do not go with the room. General nursing care has been traditionally thrown in. Many functions now done by nurses could be done by someone else. Nurses absorb work from above and from below — they absorb some of the maid's work when the maid is off duty. We need to think about what work the nurse could be doing which she doesn't do when she is doing the maid's work. We need then to consider the waste of human resources and its resultant toll of nursing attitudes.

Changing Patterns

It was Madam Chiang Kai Chek who said that we must never quarrel in the present about the past or we lose our future. We are in a period of transition and we face tremendous changes in the pattern of nursing education. Small adjustments will not do. If we had funds there would be some hope for the equalization of educational opportunity for nurses. There is a real need for studies of the cost of efficient nursing education.

If we had money the clinical program need not be so long. In the United States, under the cadet system, the organized part of the curriculum was put into thirty months, leaving six months for senior cadet experience. It was done without difficulty with students working 42-52 hours a week. Labor considers it poor practice to work 52 hours a week. More than a full work week is surely not necessary for learning. If we could run a school without service a nurse would not need 42 hours a week and so the curriculum could be put into a shorter time than thirty

months. Here we have an argument for a college course leading to a degree, which would include general education and the social sciences, psychology and sociology (all sadly lacking at the present time) and an adequate clinical experience.

There are several patterns for a changed education for nurses—such as separate and independent schools, hospital schools with separate budgets. What we are interested in is the product of whatever form nursing education takes. We want our nurse to understand how people act and react; we want her to be able to appreciate individual differences. We wish for her many points of contact with people as patients. We wish her to be able to respond to the interests of patients and to be able to stimulate interests in patients.

In any revision of the nurse's program the place of the practical nurse must be considered. Our aim is to meet the health needs of people. The professional nurse meets some of these needs. She is taking on many functions requiring special knowledge and skill. We must turn over some of our traditional work to the practical nurse. Our education is too expensive for some of our old duties—so we must delegate them. It is uneconomical to do much of what has been traditionally our work. There is room for a large group of subsidiary workers. There is room, also, for many other kinds of workers—the medical social worker, the nutritionist, the health educator. It is not necessary for a nurse to be able to fulfil all of these functions *and* provide all the nursing service in the community.

Another trend noticeable at the present time is toward setting up advanced clinical programs, particularly in psychiatry and tuberculosis. We may be entering an era of specialization in nursing. Specialization must be built upon a sound curriculum of a general and technical nature.

The Nurse as a Social Worker

HAZEL O. MANN

SOCIAL service is important to the life of the individual, the home, the community, and the nation as a whole. It became more significant through the years of war, and is now most important in these days of rehabilitation. The careful selection and preparation of the workers who will carry on this work is of supreme importance. Among these workers, there is a place for the graduate nurse who is interested and qualified.

Many personal qualities are necessary in the effectual social worker and most of these are to be found in the nurse. A pleasing personality, courage, unlimited patience, honesty, humility, and unselfishness are all attributes of a good nurse. They are the qualities needed by the social worker as she patiently listens to personal or family problems, or visits a home of meagre, below-standard, living conditions. They are invaluable as she studies the existing circumstances and possible solutions to the problems opened before her. Emotional stability, commonsense, and good judgment must be evidenced as the social worker interprets and deals with the need for or use of Mothers' Allowances, Old Age Pensions, Family Allowances, relief requests, and many other avenues of assistance being continually brought to her attention for consideration. A keen sense of humor is invaluable. She is sensitive to the pathos accompanying many an interview, and this saving ability to see the bright spots will many a time change the atmosphere of despair to one of promise and a feeling that it has been good to talk things over.

(*Please turn to page 898*)

Contributed by the Public Health Section of the Canadian Nurses Association

Staff Education—A Program that Works

PHYLLIS E. REEVE

BEFORE outlining the methods of in-service education carried out by nurses of the Metropolitan Health Committee, Vancouver, perhaps it would be a good idea briefly to describe the staff and its organization.

There are six health units in the Greater Vancouver area, each having, as far as nurses are concerned, a supervisor and anywhere from four to thirteen staff nurses. Twelve of our staff nurses and two supervisors are in municipal districts outside the Vancouver area proper and are employed by those municipalities. The remainder of the staff of thirty-nine nurses and three supervisors are employed by the Vancouver School Board, the city itself, the university and the normal school. While it is not necessary to go into the many difficulties involved in such an administrative set-up, it is easy to see that we could have a rather disjointed staff if we weren't drawn together through common policies, methods, and purposes.

The supervisors of the six units meet together twice monthly to discuss all manner of things from minute details of agency administration to the broader aspects of public health nursing and relationships with other agencies. Findings are reported to the unit staffs in their weekly Saturday morning meetings. These meetings serve to keep everyone informed of new developments and changes, and over a period of time a great many problems are discussed and solutions found for most of them. It is important that supervisors maintain this close contact with one another, but it does not quite meet the needs of the staff nurses as a whole. Some closer bond must exist between them apart from their contact through supervisors.

This is accomplished by means of the Unit Representatives Committee. In September of each year, one representative is elected by each unit (there are two for Unit I, our largest unit). She may be new to the committee, or she may have already been a member for a year, because ideally representatives are appointed for a two-year term. Usually, we have two or three new members and three or four former members, which is all to the good, since we have new ideas brought to us and experience with which to appraise them. The representatives are chosen from among those nurses who have been on the staff for at least one year, so that they are familiar with staff policies and needs. Other attributes which they have are interest, some capacity for leadership, and a desire to make a worthwhile contribution to their units and to the staff as a whole.

Most organizations are developed in answer to a need. In examining the functions of the Unit Representatives Committee we realize what those needs are; and in examining the activities it promotes we find how it meets the needs.

Objectives

1. To promote the quality of public health nursing services by strengthening the program of staff education.
2. To promote the professional growth of nurses on the staff.
3. To foster a spirit of understanding and harmony among members of the nursing staff by locating their interests and organizing social activities for groups with common interests.
4. To afford a channel through which the staff may bring its problems and make suggestions to the supervisory and administrative bodies regarding matters of supervision and agency policy.

Activities

The committee meets once a month at a time most convenient for the majority of representatives. The educational director acts as chairman and guides discussion. At the September meeting, plans are drawn up for the major staff education project for the year, each representative offering plans, ideas, and suggestions from her staff group. These are pooled and decisions reached by the discussion method. Sometimes each unit selects a different topic for study. Usually one subject is selected, each unit taking one part of it as a particular topic.

One of the most successful studies made to date was on infant health, including feeding, immunization, sleep and other health habits, training, clothing, etc. On completion of the study, findings were pooled and a set of conference guides drawn up for the nurses to use in child health centres and in the home visiting of infants. These are now revised from time to time and corrections made so that they are kept up-to-date. These guides are invaluable to a constantly changing staff in that the information given to mothers is kept uniform. They also provide a great deal of material on the care and feeding of infants which cannot be incorporated into pamphlets or kept in the nurse's head. Incidentally, these guides are now used by many other public health nurses in this and in other provinces. Last year, a study of preschool health and training was made with a view to drawing up guides for that age group. This year each unit studied syphilis and gonorrhea, as we are beginning to include follow-up work in control of the venereal diseases in our generalized service.

The choice of a major topic does not exclude other material for study. Articles of interest on a variety of subjects are taken up at the Saturday morning meetings under the direction of either the unit supervisor or representative. Also, from time to time, our pamphlet material is reviewed. Changes for old pamphlets or new ones to be printed are drawn up by the educational director, usually at the request of staff members, and submitted to the unit staff education meetings for suggestions or approval. In this way, each staff member has a voice in deciding what material is needed and what it shall comprise.

A spirit of friendship and co-operation prevails at the monthly committee meetings and is disseminated to the rest of the staff during the staff education meetings which are usually held monthly in each unit.

Certainly it would seem that the first two functions are being fulfilled. The third, too, is being fulfilled in part. We are a harmonious staff, but we have not lately engaged in any organized social activities, except for Christmas parties and gatherings to bid farewell to retiring staff or to welcome new members.

Our fourth function is carried out when there arises a need for interpretation of agency policy. The representatives bring in problems, questions, complaints, and suggestions regarding matters of personnel policies, supervision, and so on. The unrest of the world as a whole is reflected in every organization and ours is no exception. We have had several extra meetings with the senior medical health officer and the director of public health nursing in attendance to give advice and direction to our think-

ing and to help clear up many puzzling details.

Another function is fulfilled which is secondary to those discussed already, but which is, nevertheless, an important one. It concerns the individual nurse. Being a member of the committee, and acting as leader to a staff group in the activities which arise from it, promotes the professional growth of each representative and helps to prove to her and to her supervisors whether or not she is capable of developing those qualities necessary for advancement. They also give her some idea as to whether she desires promotion to a supervisory or consultant position or whether she is fitted to make her best and most satisfying contribution as a senior member of the staff nurse group.

A brief review will serve to draw our thoughts together. The Unit Representatives Committee is, as its name implies, a representative body. It acts as the hub of the wheel in staff education and relationships. It provides an excellent medium for exchange of ideas and helps to make uniform our methods of work and content of teaching material. It is the medium through which the staff nurse has a voice in drawing up agency policies. It helps to keep the administrative staff in touch with what is going on in the field. Each one of these conclusions recommends this committee as an asset to the public health nursing staff, in both principle and practice.

Ontario Public Health Nursing Service

The following are the appointments to and resignations from Ontario Public Health Nursing Service:

Appointments: *Helen Elliott* (Hamilton General Hospital and University of Toronto certificate course) as public health nurse at Oakville. *Elisabeth Scher* (Hamilton General Hospital and University of Toronto certificate course) to Hamilton Department of Health. *Susan Scales* (Guelph General Hospital and Western Ontario University certificate course) to Lennox and Addington school health service. *Leora Wright, B.A.Sc.* (Department of Nursing, University of British Columbia) to Peel County health unit staff. *Ryan Bernadette* (Pembroke Hospital and University of Ottawa School of Nursing certificate course) as public health nurse with Renfrew Board of Health. *Muriel Currie* (Royal Victoria Hospital, Montreal, and University of Toronto certificate course) to Northumberland and Durham health unit. *Vivian Kirkpatrick* (Women's College Hospital and University of Toronto certificate course) to Brant County health unit. *Margaret Lillie* (Toronto Western Hospital and University of Toronto certificate course) as public health nurse with Board of Health, Nepean Township.

Resignations: *Gertrude Finnemore* to accept position with Bureau of Public Health Nursing, Honolulu, Hawaii. *Marjorie MacEwen* (Ottawa Civic Hospital and University of Toronto certificate course) from Leaside Board of Health to accept position with Ottawa Public School Board. *Evelyn Lawrence* (Toronto Western Hospital and University of Toronto certificate course) from United Counties staff to accept position with Ottawa Collegiate Board. *Goldie Duncanson* (St. Joseph's Hospital, London, and Western Ontario University certificate course) from Chatham Board of Health.

Margaret MacKenzie (University of Toronto administration and supervision course) has returned to the United Counties health unit as supervisor. *Muriel Lowry*, who has been on leave of absence from Ontario Department of Health, is returning to the supervisory staff. *Margaret MacLachlan* (University of Toronto diploma course) is enrolled in the administration and supervisory course. She is on leave of absence from Simcoe County school health service. During her absence *Janet Burnett* will be senior nurse. *Mrs. Mabel Hatcher* (University of Western Ontario) has been granted leave of absence by the London Board of Health to pursue the administration and supervisory course at the University of Toronto.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

Notre Stage en Neuro-Psychiatrie

EDITH RICHARD *et* LOUISE RIOUX

Toute science est dommageable à celui qui n'a pas la science de la bonté.
—MONTAIGNE.

AVEC l'année 1945-46, commence pour les élèves infirmières de Ste. Justine un stage obligatoire de deux mois à St. Jean de Dieu. C'est là une heureuse initiative car de par sa profession l'infirmière est appelée à se trouver souvent en face de quelque forme de maladie de l'esprit.

En deux mois on ne peut tout apprendre sans doute, mais on nous a donné quelques notions de psychiatrie et de neurologie, on nous a enseigné la manière de reconnaître les gens qui souffrent de déficience mentale et le moyen de traiter avec eux. Nous avons changé d'idée au sujet de la folie. Nous nous imaginions que les fous sont des êtres dangereux qui font des crises de violence avec de la fureur, de l'agitation des cris, etc. Mais non, ce n'est pas toujours comme celà; c'est même rarement ainsi. Il y a à St. Jean de Dieu des malades avec qui nous avons causé pendant plusieurs jours avant de trouver quelque chose d'anormale chez eux.

Le premier service que nous avons fait fut en neurologie. Le chef de service nous a presenté des malades en cliniques; il nous a donné des cours très intéressants. Nous avons appris que les maladies du système nerveux n'atteignent pas nécessairement le psychisme, cependant ces maladies étant déprimantes, il arrive que par voie de conséquence le psychisme devient atteint. Le Dr. Panet-Raymond nous a fait faire une très belle étude du système nerveux et des maladies qui peuvent l'atteindre. Le Dr. Legrand nous a enseigné la psychiatrie. Nous avons travaillé à la salle des arrivantes, on classifie les cas, et ensuite on les dirige dans le service pour lequel elles ont été classées.

Il est intéressant d'observer la manière dont l'interrogatoire des malades est dirigé pour arriver à poser le diagnostic. Deux fois la semaine on nous présentait des malades en clinique. Il faut parfois remonter jusqu'à la première enfance pour trouver la cause des troubles que présente le malade. Nous avons vu les cas les plus graves dont quelques uns sont malheureusement incurables, jusqu'aux plus légers troubles qu'un peu d'hygiène suffit à enrayer. Le Dr. Loignon nous a montré les ravages causés par la syphilis nerveuse.

Les médecins manifestent pour notre stage un véritable intérêt, se font un plaisir d'apporter une correction à nos histoires de cas. Ces histoires de cas sont des devoirs que comprennent l'étude d'un patient choisi dans notre salle. Nous recherchons les antécédents héréditaires et personnels qui ont pu provoquer la maladie, nous étudions l'évolution de cette maladie depuis le début, l'état actuel, le traitement, et les résultats apportés par ce traitement.

C'est un travail qui demande beaucoup de recherche et ainsi contribue grandement à développer notre sens d'observation. Les religieuses

officières des départements apportent aussi une large part dans l'exécution de ce travail en nous aidant à connaitre et à comprendre nos malades. A chaque quinzaine ces histoires de cas sont remises à la directrice, soeur Augustine, qui les corrige.

A l'école nous avions des cours théoriques bien préparés que nous donnait la directrice. Elle nous a donné des conseils sur la manière de traiter avec les malades, des notions de psychologie du malade mental.

Durant les courtes semaines passées dans chaque département nous avons pu acquérir quelques notions sur les traitements que l'on emploie pour guérir ou du moins améliorer les differentes maladies que l'on rencontre là-bas. Nous avons suivi avec intérêt les effets sédatifs des bains prolongés chez les agités, les progrès merveilleux apportés par le traitement de l'électro-choc, et le traitement psychothérapique.

Nous avons appris durant ce stage à comprendre l'aliéné; nous avons appris à lui donner beaucoup de confiance, à lui manifester une grande bonté. Quelle est maintenant la valeur pratique de ce stage pour nous? Nous nous réjouissons à penser à tout ce que peut maintenant représenter pour nous un tel stage. Cette étude de la psychiatrie nous a:

1. Enseigné les changements qui surviennent dans l'état mental des malades physiques.

2. Expliqué les relations existant entre la vie physique et mentale et les maladies mentales et physiques.

3. Appris à considérer la conduite comme un symptôme.

4. Appris à observer et à différencier la conduite anormale de la même façon que l'on observe les signes physiques anormaux.

5. Fait comprendre l'importance de reconnaître que la cause éloignée dans la majorité des cas de troubles nerveux et mentaux remonte à l'enfance et n'est pas nécessairement héréditaire.

De plus, grâce à ces courtes études, nous possédons maintenant—

6. Une connaissance élémentaire mais authentique du mécanisme mental qui motive et explique la conduite.

Comme application purement personnelle ce cours nous apprend (7) à diriger notre attention vers une conception d'esprit exprimée dans la conduite habituelle et (8) l'adoption aux circonstances de la vie avec (9) le désir d'augmenter notre propre stabilité mentale; (10) une compréhension plus sympathique de la nature humaine.

Pour résumer, nous pouvons affirmer que notre cours est plus complet avec notre stage à St. Jean de Dieu.

LE PROGRAMME DU STAGE EN PSYCHIATRIE A L'HOPITAL ST. JEAN DE DIEU

Un cours de psychiatrie appliqué, par semaine, par la directrice de l'école.

Une clinique, par semaine, par le Dr. Emile Legrand, professeur de psychiatrie, ou le Dr. Jean Panet-Raymond, spécialiste en neurologie, ou le Dr. Loignon, chef du service de syphiligraphie.

Deux ou trois séances à la salle d'autopsie, pour étude du système nerveux.

Visites de l'hôpital et des différents départements—occupations thérapeutiques, ateliers, Ecole Emmélie Tavernier, etc.

Cours: 12 cours sur les sujets suivants préliminaires, renseignements, explications, l'hôpital neuro-psychiatrique—ce qu'il n'est pas, ce qu'il est; études de cas: comment les faire, explications, modèles, qualités nécessaires pour le soin des aliénés. Attitude des élèves. Rapports avec les malades (3). Comment profiter du stage. Traitements spéciaux. Neurologie: termes spéciaux, n é v r o s e s. Troubles mentaux les plus importants. Psychothérapie.

Walking Parties

"Walking parties" are a common sight throughout China today. These are the groups which make up the forty million Chinese uprooted from their homes by the war and making the long journey home by foot. With China's internal transport completely shattered by the war, the government is unable to provide transportation for any but a few of these displaced. Day after day these groups proceed afoot in loosely organized groups, usually protected from marauders by armed guards. —*UNRRA News*

Interesting People

The names of the officers of the C.N.A., elected at the recent convention, have already been announced. Names mean little to the thousands of nurses across Canada. That you may become better acquainted with each of these personages, the following word-pictures will serve as introductions:

The first vice-president, **Ethel Mildred Cryderman,** was born in Walkerton, Ont. Five generations ago, her ancestors came to Canada from Holland. She finished high school in Walkerton then entered the school of nursing of the Toronto General Hospital. Following graduation in 1916, Miss Cryderman spent a year in private duty nursing, then joined the Royal Canadian Army Medical Corps with which she served overseas until 1919. She received mention in despatches in 1918.

Upon her discharge from service, Miss Cryderman decided to qualify herself for public health nursing work. She received her certificate in that course from the school of nursing of the University of Toronto. She also holds her midwifery certificate from Radcliffe Infirmary, Oxford, and for the Mothercraft course obtained in London, Eng.

Thus equipped, Miss Cryderman joined the staff of the Department of Public Health in Toronto in 1921. Four years later she became a district supervisor with that organization. In 1929, she joined the Victorian Order of Nurses as a central supervisor, going to her present position as director of the Toronto Branch of the Order in 1934.

Miss Cryderman has always maintained a very active interest in the work of her professional associations. She has been president of the Registered Nurses Association of Ontario, and chairman of various committees, including the Public Health Section of the R.N.A.O. She is a past president of the alumnae association of the Toronto General Hospital School of Nursing. Miss Cryderman has been second vice-president of the C.N.A. since 1944.

The strenuous demands of her work have left her little time for relaxation. However, she is a member of the Zonta Club and enjoys paddling, walking, and gardening.

The new second vice-president, **Harriet Evelyn Mallory,** is very well-informed on the activities of the C.N.A. having been a member of the executive, 1939-41, when she was president of the Manitoba Association of Registered Nurses, and as honorary secretary of the C.N.A., 1944-46. At the present time she holds dual membership as she has been president of the Registered Nurses' Association of British Columbia since 1945.

Born in Barrie, Ont., Miss Mallory received her education in Winnipeg. She graduated from the Winnipeg General Hospital in 1925 and obtained her academic degree and diploma as teacher in schools of nursing from Teachers College, Columbia University, in 1930. She served as instructor at the Winnipeg and Vancouver General Hospitals. Later, she became superintendent of nurses at the Children's Hospital, Winnipeg.

In 1941, Miss Mallory was appointed reg-

ETHEL CRYDERMAN

Marlow, Vancouver

EVELYN MALLORY

istrar and educational adviser with the British Columbia association. Two years later she joined the faculty of the University of B.C. as associate professor in the Department of Nursing and Health, instructing in the courses in teaching and supervision in schools of nursing. This experience all has helped to provide her with an intimate knowledge and understanding of the problems which confront nursing today.

A newcomer among the executive officers of the C.N.A. is **Reverend Sister Marie Denise Lefebvre, s.g.m.,** who is now the honorary secretary. Born and educated in Quebec, Sister Lefebvre graduated from St. Boniface Hospital, Man., in 1932. She received her Bachelor of Arts degree from the University of Montreal in 1935, her Bachelor of Science in nursing education from St. Louis University in 1938, and her Master of Science degree from the Catholic University of America, Washington, D.C., in 1939. At present, Sister Lefebvre is instructor in nursing education and psychology at the Institut Marguerite d'Youville, Montreal. She made a splendid contribution when, as travelling instructor, she assisted with the organization of clinical teaching programs in various of the French-speaking schools of nursing. She has undertaken much personal research into the improvement of the curriculum of these schools of nursing.

Sister Lefebvre has been active on numerous committees in the Registered Nurses Association of the Province of Quebec. She is convener of the French division of the Hospital and School of Nursing Section. She is co-author of a book on principles and procedures in nursing, which is now at the press, entitled "Initiation a l'Art du Soin des Malades."

Her extensive professional background and her lively interest in nursing fit her admirably for this office of leadership.

Two years in the presidency of the Manitoba Association of Registered Nurses provided **Lillian Ethel Pettigrew** with a sound understanding of C.N.A. activities which will be of value to her in her new position as honorary treasurer.

A native daughter of Lumsden, Sask., Miss Pettigrew entered the school of nursing of the Winnipeg General Hospital in 1928. She was

SISTER DENISE LEFEBVRE

awarded a scholarship upon graduation and proceeded to take her course in public health nursing at the McGill School for Graduate Nurses. For the next seven years she was assistant to the executive secretary of the C.N.A., joining the staff of the Victorian Order of Nurses, Toronto, in 1940. In 1943, she accepted her present position as health instructor at the Winnipeg General Hospital.

Miss Pettigrew is fond of skating and golf. A game of bridge provides indoor relaxation. Recently she has been learning to dabble with water-colors.

Dorothy Mary Riches, R.R.C., has been appointed director of the school of nursing at Queen's University. She will have

Davidson Studio, Winnipeg

LILLIAN PETTIGREW

the responsibility of developing the final year programs of nursing administration and public health nursing for this five-year course which was initiated in conjunction with the Kingston General Hospital.

Recently discharged from the R.C.A.M.C., where she had latterly been matron-in-chief of nursing service overseas, Miss Riches has a broad background of preparation and experience. She is a graduate in Arts of the University of Saskatchewan and of the Royal Victoria Hospital, Montreal. Immediately upon completion of her training, Miss Riches undertook post-graduate experience in England, Germany, and Switzerland. After two years as head nurse on a medical ward at the Royal Victoria Hospital, she further qualified herself by taking the course in administration and teaching at the McGill School for Graduate Nurses. She was engaged as senior instructor at the Royal Jubilee Hospital, Victoria, prior to her enlistment with the R.C.A.M.C.

Miss Riches went overseas as matron of No. 8 Canadian General Hospital in 1941. A year later she was promoted to the rank of Major (Principal Matron). In 1943 she was posted to the office of A.M.D. 4, Director of Medical Services Branch. She was awarded the Royal Red Cross in the 1944 New Year's Honours List.

To her new work, Miss Riches brings qualities of sincerity and industry which bode well for her success. Her pleasant yet forceful personality, her belief in the ultimate goal of nursing, and her kindly interest assure her future students of a wise counsellor and friend.

MARGARET BALLARD

Margaret Blanche Ballard has become chief of the Division of Hospital and School of Nursing administration at the University of Western Ontario.

Born in Moose Jaw, Miss Ballard received her preliminary education there. She graduated with the degree of Bachelor of Arts from the University of Saskatchewan in 1939. Following graduation from the school of nursing of the Toronto General Hospital, she worked as night supervisor in the obstetrical unit there. In 1944, Miss Ballard received her degree of Bachelor of Science (Nursing) from the University of Western Ontario. For the past two years she has been nursing arts instructor at the Toronto General Hospital.

Miss Ballard is interested in the activities of her alumnae and of the provincial association. She is a member of the Personnel Committee of the Student Christian Movement of Canada. She has been vice-president and leader of the Young People's Association in her church. She is proficient in tennis and badminton. All of these factors will make her a valuable member of the teaching department in her new work.

After serving for three years with the R.C.A.M.C., **Laura B. M. Fair, A.R.R.C.,** has assumed the office of executive secretary of the Manitoba Association of Registered Nurses.

Of Irish descent, Miss Fair was born and educated at Sunderland, Ont. She graduated in 1932 from the Ontario Hospital in Whitby, with affiliation at the Toronto General Hos-

Ashley & Crippen, Toronto

LAURA FAIR

pital. After five years as a ward supervisor, Miss Fair enrolled with the school of nursing of the University of Toronto for the course in hospital administration and teaching in schools of nursing. She served as an instructor from 1938 until her enlistment with the R.C.A.M.C. in 1943.

Following nine months at Camp Borden, Captain (Matron) Fair proceeded to England. Thirteen months later she was transferred to active duty in the war zone, serving in Belgium and Holland. She was listed as an Associate to the Royal Red Cross in the 1946 King's Birthday Honors.

In assuming her new duties, Miss Fair brings to her work great interest and energy. Our heartiest good wishes for success in her undertaking.

Clara E. Jackson has been appointed as director of Nurse Placement Service and travelling instructor with the Saskatchewan Registered Nurses' Association. She had filled the latter position very ably for a few months in 1943.

Miss Jackson's interest in nursing began thirty years ago when, as a Canadian Nursing V.A.D., she served overseas with a Casualty Clearing Station for two years — being recommended for efficiency and receiving the coveted award from the British War Office. Returning to Canada, Miss Jackson entered The Montreal General Hospital School for Nurses, graduating in 1922. She was awarded a Governor's Scholarship for executive ability at that time.

Miss Jackson is also a graduate in administration and teaching of the McGill School for Graduate Nurses. She has served in the capacity of ward supervisor, director of education and hospital administration in Montreal, Nanaimo and Duncan, B.C., Brantford and Collingwood, Ont. She is very interested in everything pertaining to advancement in the nursing field, better nursing care for patients, better care of nurses, and believes every nurse should be a health missionary. With all of this professional activity, Miss Jackson finds time for the occasional game of golf or badminton, enjoys a game of bridge, or a nice quiet time with a book.

Vera Beatrice Eidt, who saw service with the hospital ship, *Letitia*, during her years in the R.C.A.M.C., has recently been appointed

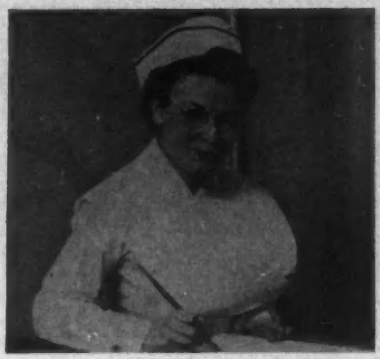
CLARA JACKSON

superintendent of the Trail-Tadanac Hospital, Trail, B.C. Miss Eidt is no stranger to the Kootenay area for she had served for eleven years as assistant superintendent and hospital administrator at the Kootenay Lake General Hospital in Nelson, B.C.

Hailing from Port Elgin, Ont., Miss Eidt graduated in 1922 from the Guelph General Hospital. After a year of private duty, she joined the staff of the Cleveland Clinic Hospital. In 1928, she became a ward supervisor at the Royal Inland Hospital, Kamloops, B.C. In 1942, she enrolled for the course in hospital administration at the University of Toronto School of Nursing. Following completion of this course, Miss Eidt went to the Lady Minto Hospital, Cochrane, Ont., where she was superintendent until her enlistment in the R.C.A.M.C.

Miss Eidt has been active in nursing associations having been president of the

VERA B. EIDT



Stride Studio

MONA PARSONS

Nelson Chapter and of the West Kootenay District of the Registered Nurses' Association of British Columbia. She is a sports enthusiast when time permits. She feels that some form of indoor hobby is essential for every nurse, being proficient in leather work herself.

Mona Ellen Parsons has assumed the responsibilities of superintendent of nurses at the Provincial Mental Hospital, Essondale, B.C.

Miss Parsons was born and educated in Killarney, Man. In 1926, she graduated from the Brandon Mental Hospital. For the next four years she was in charge of a male psychiatric unit at Brandon then followed this experience by further training at St. Boniface Hospital where she graduated in 1933. She returned to the Brandon Mental Hospital for a year as supervisor, then joined the staff of the Provincial Mental Hospital at Essondale as instructor. In 1937, Miss Parsons secured her certificate in teaching and supervision in schools of nursing from the University of Washington, Seattle, returning to her post as instructor. Her long experience with the work of mental hospitals gives Miss Parsons an excellent perspective of the new duties she has undertaken.

Notman, Montreal

CLARA PRESTON

The distinction of being the only Canadian nurse returning to her duties in the mission hospitals in China goes to **Louise Clara Preston,** who sailed recently to resume her war-interrupted work in Honan Province under the auspices of the United Church of Canada.

Miss Preston grew up in Stratford, Ont. She graduated in 1922 from Royal Victoria Hospital, Montreal, and volunteered at once for missionary nursing service. After three years' study of the Chinese language, she became superintendent of nurses at Changte Hospital. In 1927 she was forced to leave there because of civil strife. On her return to Canada, she qualified for the certificate in teaching and supervision at the McGill School for Graduate Nurses. For the next two years she was practical instructor at Victoria Hospital, London, Ont. Before returning to Changte Hospital, Miss Preston secured her certificate in hospital administration at Western Ontario University, London.

With Changte Hospital completely refurnished, Miss Preston opened a school of nursing there in 1932. In 1937, the Japanese invasion closed the school and Miss Preston returned to Canada. Desiring still more preparation, she enrolled again at Western Ontario University and obtained her certificate in public health nursing. She went back to China and served as public health nurse at Yen Ching until again forced to flee. She went to Chungking as superintendent of nurses of the Canadian hospital and endured a good many months of bombing before ill-health necessitated her return to Canada in 1943. She helped out during the nurse shortage here by acting as superintendent of nurses at the United Church hospital in Hearst, Ont.

We rejoice with Miss Preston that the way has opened for her return to her beloved China. Our good wishes follow her as she resumes her task.

Winnifred Laurier Chute has left her work as lecturer and demonstrator in science at the University of Toronto School of Nursing to teach physiology and nutrition in the school of nursing connected with the medical college at Vellore, India.

Miss Chute secured her Arts degree from Acadia University, Wolfville, N.S. She graduated from Royal Victoria Hospital, Montreal, in 1925. She holds her teaching diploma from the McGill School for Graduate Nurses. She has been instructor at the Sherbrooke Hospital and at the Brantford General Hospital. Formerly a member of the Ladies Golf and Tennis Club of Toronto, Miss Chute possesses the well-rounded personality that will endear her to her future students in India. Our good wishes accompany her in her new work.

Christena Catherine Gillies has celebrated her silver anniversary as supervisor of the eye, ear, nose and throat ward at Victoria Hospital, London, Ont. Graduating from the school of nursing of Victoria Hospital in 1920, Miss Gillies did special duty nursing for a few months then joined the staff.

The alumnae association, with its many activities, has claimed a fair share of Miss Gillies' attention. Indoor bowling was her favorite sport. She enjoys sewing, reading, a bit of cooking, picnics and gardening (in moderation). We wish for Miss Gillies many years of happy service in her work where she has been successful for so long.

Olive Garrood, public health nurse of Kamloops, B.C., has recently retired from active work. Born in Adelaide, Australia, Miss Garrood graduated from the Adelaide General Hospital. She then took a post-graduate course in obstetrics at the Crown St. Women's Hospital, Sydney. Following this she was appointed district nurse in Goolwa, South Australia, by the District Trained Nurses' Association.

In the latter part of 1920 Miss Garrood went to New Zealand where she travelled and did private duty nursing for two years. In 1922 she took a post-graduate course in public health, specializing in child welfare. This course was under the auspices of the Royal New Zealand Society for Women and Children, founded by Sir Truby King.

After four years in public health work in New Zealand Miss Garrood came to Canada in June, 1926. Shortly after her arrival, she was appointed as public health nurse to the Kootenay Lake district in British Columbia. In October, 1927, she transferred to Kamloops as public health and school nurse.

Darvagh, London

CHRISTENA GILLIES

During the past nineteen years her activities have been many and varied. She served for two years as president of the Kamloops-Tranquille Chapter and then as president of the Kamloops-Okanagan District. Members of both organizations will remember her presidency as years when the new chapter and district became more firmly established.

Miss Garrood received an honorary life membership in the St. John Ambulance Association in recognition of her cheerful, generous assistance with their work. Her chief hobbies are Little Theatre work, literature, and weaving. She visited Europe twice in

OLIVE GARROOD

pre-war years and is now eagerly awaiting passage to Australia for a year's visit at home. Then she plans to return to a little cottage on Garrow Bay in West Vancouver. Her many friends wish her happy, healthy years to enjoy her well-earned leisure.

Obituaries

The many friends of **Margaret V. Allan** will be deeply grieved to learn of her death in Vancouver on August 3, 1946. Miss Allan nursed in both the United States and Canada for a number of years. She was instructor at the Hartford General Hospital and, during World War I, at the Winnipeg General Hospital. Probably Miss Allan's greatest contribution was made as superintendent of nurses at the Children's Hospital, Winnipeg, a position which she occupied with signal success for nine years, an enviable service record. She retired from this position in 1935 and spent a good deal of time subsequently in travelling and sharing her experiences with many friends.

In spite of poor health, Miss Allan managed to make professional contributions during World War II. She taught courses in home nursing for the St. John Ambulance Association in Vancouver and later relieved for a short time on the nursing staff of the Royal Columbian Hospital, New Westminster, B.C.

Gertrude M. Curry died recently in Victoria, B.C. A graduate in 1907 of the Pembroke, (Ont.) Cottage Hospital, Miss Curry engaged in private duty nursing for a time after moving to British Columbia. She was on the staff of the Chemainus General Hospital prior to enrolling for the course in public health nursing at the University of B.C. After completing the course in 1922, Miss Curry was employed with the Provincial Board of Health in B.C. In 1928, she joined the staff of the school of nursing of the Royal Jubilee Hospital in Victoria. Some four years ago, Miss Curry developed an industrial program for the Sidney Roofing Co., with which service she was associated until recently.

Emma Edith Grainger, who was for some years with the social service department of Christie St. Hospital, Toronto, died in that city on July 16, 1946. Miss Grainger was born at Walkerton, Ont. She graduated from Lowell Hospital, Mass., later taking post-graduate work in Boston. During World War I she served as a nursing sister in England and France. Miss Grainger had been retired for several years because of ill health.

Margaret Rendle Peake, who was trained at the Post-Graduate Hospital, New York, and who had resided in Toronto since 1929, died recently.

Catherine Isabella Snodgrass, who graduated from the Toronto General Hospital in 1898, passed away in Toronto.

Margaret Scott Stephen, who graduated from St. Paul's Hospital, Saskatoon, in 1922, died on August 16, 1946. Born in Scotland, Miss Stephen came to Canada in her early youth, and lived at Brock, Sask. Following graduation, she joined the staff of the Saskatoon Sanatorium when it was first opened. Subsequently, she nursed at other points in Saskatchewan and in B.C. She retired from nursing in 1930 because of ill health.

Jessie Wood, a graduate of the Johns Hopkins School of Nursing, Baltimore, died recently in Preston, Ont.

Sulfaiodines

A new series of compounds, known as sulfaiodines, which combine the most useful features of sulfonamides and iodine for the treatment of wounds, has been reported. Chemical combination of sulfonamides with a relatively small amount of iodine gives these compounds the enormous advantage of non-selectivity in their attack on bacteria, the research scientist originator claims. "No pathogenic organism has yet been encountered which resists the antibacterial action, *in vitro*, of the sulfaiodines." In this respect they may prove more useful than previous sulfonamide combinations or penicillin.

Notes from National Office

Off to Great Britain

MISS RAE CHITTICK, president of the Canadian Nurses Association, sailed for London from Halifax on the *Georgic* on July 19. Miss Gertrude Hall, general secretary, and Miss E. K. Russell, director of the University of Toronto School of Nursing, left Halifax on August 18 on the *Aquitania* for London. They will all attend meetings of the Board of Directors of the International Council of Nurses and of the Grand Council of the Florence Nightingale International Foundation. Miss Hall will remain in Great Britain for three weeks to make a study of nursing conditions in that country. A program of visits to hospitals and universities in England and Scotland has been arranged by Dame Watt, chief nursing officer of the British Ministry of Health.

International Conference of the National Council of Women of the United States and Canada

A brief resume of the proceedings is herewith reported by our representative, Miss Gladys Sharpe, who attended the meetings held in New York, May 6-8, 1946:

At the opening session the keynote address, "Peace in the New World", was a fitting introduction to the discussions which followed. This theme was developed during the subsequent sessions by five panels in which representatives of the continents of North America, South America, Asia, Europe, and Australia participated. Each panel emphasized five world-wide problems, namely, Starvation, Homelessness, Denial of Human Rights, Nationalism, and Economic Barriers.

There was a striking similarity in the views expressed by each speaker, irrespective of geographical representation, race, or creed, in an outspoken acknowledgment of the responsibilities in meeting "The Challenges to the Peace of the World." The following selections will serve to illustrate these attitudes:

We are not only our brothers' *keeper*, but our brothers' *brother*. We are eager to do what we can as individuals and as groups. We must display an absolutely sincere, devoted, and unswerving adherence to the principle of the brotherhood of man and the Fatherhood of God. It is time to stop talking and act. Women must integrate nationalism into internationalism.

Specific ways in which women can answer their responsibility were outlined in four rules for "Good Citizenship in a World Community." These rules, proposed as "conduct guides for every woman everywhere" by the executive committee of the United States group, were read to the delegates, by the celebrated actress, Miss Jane Cowl, as follows:

I shall do all that lies in my power to fulfil the responsibilities of good citizenship in a world community, by urging the active participation of qualified women in local, state, national and international government; by using my ballot always for the benefit of the greater number; by protesting immediately to my Government against any encroachment upon the human rights and fundamental freedoms of my global neighbors, anywhere; and by demonstrating in my home and my community my firm belief in the precept of human brotherhood as the foundation of a lasting world peace. This is a program I gladly adopt as the minimum of my obligations to society; but I shall seek, constantly, other ways of strengthening the hands of men and women of goodwill everywhere for the betterment of the human race, so help me God.

The sessions concluded with the formulation of certain resolutions which are incorporated in the minutes of the proceedings. Each meeting during the three-day period was one of inspiration. We were acutely aware of the dominant note of "Oneness" which prevailed and it is believed that as the representatives of many groups return to their organizations each will carry an affirmed purpose—of proclaiming the truth—that only as "Citizens of the World" can women accept "The Challenges to the Peace of the World."

Royal Canadian Air Force Nursing Service

When the *Journal* went to press in July, 1946, the list of the decorations won by the R.C.A.F. nursing sisters was not available. We now publish the following names obtained from the Deputy Minister of National Defence:

Royal Red Cross: E. M. Elder.

Associate Royal Red Cross: F. M. Oakes, D. T. G. Bourke, M. J. Douglas, R. P. McSorley, A. A. Lamont, M. J. Cleary, H. B. Sabine, E. B. Churchill, D. A. Bilton, E. R. Farquharson, M. E. Jackson, J. E. C. Porteous, D. C. Lindsay, L. E. Johnstone, K. M. Leslie, A. J. Leitch, M. E. McCracken, A. M. Laroche, M. M. Trotter, H. E. Hughes.

Mentioned in Despatches: H. M. Fox.

King's Commendation: H. M. Brown.

Royal College of Nursing

The following information has been gathered from notes submitted by the Royal College of Nursing:

The training of industrial nurses: The Advisory Board on Nursing Education recommended to council a scheme for the training of industrial nurses. Under this scheme the training of industrial nurses would be carried out in the university departments of industrial health in preparation for the industrial nursing certificate of the Royal College of Nursing. Where university departments in industrial health are not in a position to undertake training, the Royal College of Nursing could be responsible for the organization of the course in co-operation with such department; a Board of Studies in Industrial Nursing to be set up to prepare entrance regulations; to draw up a course of study and keep it under revision; to elect a panel of examiners; to be responsible for the conduct of examinations. The Board of Studies should consist of representatives from universities where Departments of Industrial Health are set up, five representatives of the Advisory Board on Nursing Education, and two representatives of other appropriate bodies. It was felt that such a Board of Studies might well prove the prototype for similar boards for other courses and subjects. (This is very timely as we in Canada have courses in industrial nursing under review at the present time.)

The professional Association Committee reported work with other interested organizations on the subject of a comprehensive superannuation scheme for all nurses and midwives; also on a deputation to the Minister of National Insurance on the need for special machinery for the administration of unemployment insurance for nurses. We shall await with keen interest further news of development of this committee.

Correspondence

Helen, Duchess of Northumberland, G.C.V.O., C.B.E., president of the British Empire Nurses War Memorial Fund, has written the following letter to the general secretary, Canadian Nurses Association:

Dear Miss Hall,

I was delighted to receive your letter enclosing the cheque for one hundred dollars, and ask you to convey to the Canadian Nurses Association my very grateful thanks for their most welcome gift. It is indeed good of them to send a token grant to the British Empire Nurses War Memorial Fund, and we in this country appreciate it all the more since it is an evidence of the friendship between the nurses of your great Dominion and the nurses of Great Britain.

I have been well aware of the generous way in which you in Canada have been helping the nurses of this country, and not only them, but your colleagues in the Netherlands, and know that this further gift will give great satisfaction to the nurses here.

I am sure that the nurses of Canada will be delighted to know that Her Majesty the Queen has graciously consented to be the Patron of the British Empire Nurses War Memorial Fund.

I was most interested to hear that you have your own Canadian Nurses War Memorial Committee for the establishment of libraries for nurses in European countries and hope that you will keep me in touch with the progress of your project. We, too, are hoping that the larger purpose of the B.E.N.W.M.F., beyond the establishment of the Chapel in Westminster Abbey, will be such as will help the nurses and midwives in the British Commonwealth and Empire in some way as will your own memorial.

May I, therefore, send my best wishes to you for success in your project and again thank you for your generosity to the B.E.N.-W.M.F.

Yours sincerely,
(*Sgd.*) HELEN NORTHUMBERLAND
President

Information Please!

Anyone knowing the addresses of Mary MacNutt and Miss Reuter please communicate with National Office.

Correction

Comparative report for 1939-45, showing the nursing situation in British Columbia, which appeared on page 679 of the August issue of *The Canadian Nurse*, should read 1011 per cent graduate nurses serving in D.V.A. hospitals, instead of 101.1 per cent as printed. We regret this error.

Notes du Secrétariat de l'A.I.C.

DÉPART POUR LA GRANDE-BRETAGNE

Mlle Rae Chittick, présidente de l'A.I.C., Mlle Gertrude Hall, secrétaire, et Mlle E. K. Russell, directrice de l'école des infirmières de l'Université de Toronto, sont en route pour l'Angleterre. Elles assisteront à une réunion du Conseil International des Infirmières et aussi au Grand Conseil de la fondation internationale Florence Nightingale. Mlle Hall prolongera son séjour de trois semaines pour étudier la situation du nursing dans ce pays.

CONFÉRENCE INTERNATIONALE DU CONSEIL DES FEMMES DES ETATS-UNIS ET DU CANADA

Voici un court résumé des débats tel que rapportés par notre représentante, Mlle Gladys Sharpe, qui était présente aux assemblées tenues à New York du 6 au 8 mai, 1946:

L'idée dominante du discours à l'ouverture de la séance fut "Paix au Nouveau Monde." Ce sujet fut développé durant les assemblées suivantes par cinq groupes composés de représentantes de l'Amérique du Nord, de l'Amérique du Sud, de l'Asie, de l'Europe, et de l'Australie. Chaque groupe fit ressortir les cinq grandes questions à l'ordre du jour dans le monde entier, à savoir: la famine, les sans foyers, la dénégation des droits de l'homme, les barrières économiques et nationales.

Les idées exprimées par chacun des orateurs étaient souvent semblables, bien qu'ils fussent de pays différents, d'une autre race, et ne partageant pas la même religion; l'on reconnu ouvertement sur qui repose la responsabilité de combattre ce qui peut menacer la paix du monde. Les phrases suivantes illustrent leur manière de penser:

"Nous ne sommes non seulement le gardien de notre frère mais aussi son frère. Nous sommes anxieux de faire tout en notre pouvoir comme individu et comme groupe. Il faut montrer une adhésion absolue, sincère, dévouée, et inébranlable dans le principe que tous les hommes sont frères et que Dieu est le père du genre humain. Il est temps de cesser de parler et d'agir."

Chacune des assemblées durant ces trois jours furent d'une grande inspiration.

R.C.A.F.N.S.

La liste des infirmières du corps royal canadien de l'armée de l'air ayant reçu des décorations, parait à la suite des notes du secrétariat général.

NOTE DU COLLÈGE ROYAL DES INFIRMIÈRES

La formation de l'infirmière industrielle: Le comité des aviseurs de la section de l'éducation recommande que des arrangements soient pris pour la formation des infirmières industrielles. Le département de l'hygiène industrielle des universités serait chargé de la formation de ces infirmières. Après ce cours elles seraient qualifiées pour recevoir le certificat en hygiène industrielle de la part du collège Royal des Infirmières. Là où les universités ne seront pas en mesure d'entreprendre ce cours, le collège Royal des Infirmières s'en chargera en co-opération avec le département; il fut aussi recommandé qu'un comité d'étude en nursing industriel soit nommé afin de déterminer les conditions d'admission, afin d'établir un programme d'étude et de le reviser au besoin, afin d'élire un bureau d'examinateurs, et afin d'assumer la responsabilité de ces examens. Le comité d'étude sera composé de représentants des universités ayant un département d'hygiène industrielle, de cinq représentantes du comité d'éducation, et de deux représentants d'autres groupes. On est d'avis qu'un tel comité d'étude pourrait servir de modèle pour d'autres comités d'étude qui aimerait soit à organiser un autre cours, soit à enseigner une matière.

Au Canada, nous étudions actuellement la possibilité d'un cours en hygiène industrielle.

Le comité des intérêts professionnels rapporte que, conjointement avec d'autres organisations, l'on travaille à un plan détaillé et complet de pension viagère pour toutes les infirmières et sages-femmes, et aussi à une représentation auprès du Ministre des Assurances nationales, sur les besoins d'un arrangement spécial dans l'administration de l'assurance-chômage pour les infirmières. Le rapport de ce comité est toujours attendu avec intérêt.

CORRESPONDANCE

La lettre suivante est écrite par la duchesse de Northumberland, G.C.V.O., C.B.E., présidente du comité de souscription de l'empire britannique en mémoire des infirmières de la guerre:

"Chère Mlle Hall,

Il me fait grand plaisir de recevoir votre lettre contenant un chèque de cent dollars. Je vous demande de transmettre mes remerciements à l'Association des Infirmières du Canada pour ce don très apprécié. C'est très bon de votre part d'envoyer ce témoignage de sympathie et nous dans ce pays nous l'acceptons comme une marque évidente d'amitié entre les infirmières des Dominions et les infirmières d'Angleterre.

"Je suis très au courant de quelle façon généreuse dont vous, au Canada, avez aidé les infirmières de notre pays, non seulement les nôtres mais aussi vos compagnes de Hollande. Et je sais que ce dernier don que vous venez de faire sera un motif de contentement pour nos infirmières.

"Je fus très intéressée d'apprendre que vous avez un comité de souscription en mémoire des infirmières canadiennes de la présente guerre, que le but proposé est l'établissement de bibliothèques dans les pays d'Europe. J'espère que vous me tiendrez au courant de vos progrès. Nous espérons, nous aussi, qu'en plus de l'érection d'une chapelle dans l'abbaye de Westminster, que la plus grande partie de notre souscription sera employée à aider les infirmières et les sages-femmes du Commonwealth britannique et de l'empire.

"Puis-je vous adresser tous mes voeux pour le succès de vos entreprises et mes remerciements pour votre générosité.

Sincèrement vôtre,

HELEN NORTHUMBERLAND,
Présidente."

QUELQUES LECTURES À FAIRE

Dans les hôpitaux l'époque des vacances est souvent celle qui laisse le moins de loisir. Il se peut que faute de temps vous ayez négligé de lire nos revues. Nous nous permettons de vous signaler quelques articles que nous trouvons d'une grande valeur:

Dans le *Bulletin des Infirmières Catholiques du Canada*, no mai et juin: Mesures Disciplinaires dans les Ecoles d'Infirmières, Soeur St-Paul, g.m.e., Hôpital St-François d'Assise; no juillet et août: La Directrice des Infirmières au Service du Malade, Rév. Soeur M. E. Rhéault, B.Sc.H., Hôpital Notre-Dame; *The Canadian Hospital*, no d'août: Changes Inevitable in Nursing System, R. A. Seymour, M.D. Cet article nous a paru si important qu'il a été traduit en français et nous serons heureuses d'en envoyer une copie à qui en fera la demande. A l'Edition de l'Arbre, vient de paraître "Initiation à la Médecine" par le docteur G. Hébert. Voir le compte rendu en français dans "Book Reviews."

Liver, preferably pork liver, once a week is essential in any normal diet.

Annual Meeting in Nova Scotia

The thirty-seventh annual meeting of the Registered Nurses' Association of Nova Scotia was held recently in Amherst on May 30 and 31, 1946, with approximately seventy members in attendance and all branches of the province represented. The invocation was delivered by the Rev. H. Olsen, pastor of the First Baptist Church, and a most cordial address of welcome was delivered by His Worship, Mayor N. S. Sanford.

The meeting was called to order by Rhoda MacDonald, president of the association, who, in her opening remarks, dealt with the present critical shortage of nursing personnel and the proposed new Constitution and By-laws of the C.N.A., as well as a proposed Nurse Practice Act under which licensing would be necessary for all members of the profession, including registered, graduate, and practical nurses who desire to practise in Nova Scotia. Miss MacDonald referred also to the work of the Placement Bureau and the necessity for further financing now that the Government Grant is no longer available for this purpose, and the action of the Federal Government in opening a school for practical nurses at Moncton, N.B. At the request of Mary S. Patterson, Maritime supervisor of Rehabilitation and Vocational Training, the association considered applications for the position of instructor at this school with the result that Adelaide Munroe, instructor at Yarmouth Hospital, was appointed.

The paid-up membership of the association, as at August 31, 1945, was 1,527, representing an increase of 89 members over the previous year. During the year the association became affiliated with the Provincial Council of Women of Nova Scotia.

Reports from the branches indicated an active year and a growing realization of the need for more definite action and greater co-operation on the part of the association and its individual members. The General Nursing Section, convened by Mabel MacPhail, gave much of its time during the year to discussions respecting the formation of so-called "Interest Groups" to replace the present sections. Regular meetings of the Public Health Section, convened by Margaret P. Ross, were held and many matters of importance were discussed, chief among which was the possibility of obtaining a refresher course on Job Instruction. It was later decided, however, that such a course was not suitable to large groups and the matter was allowed to lapse. The report of the Hospital and School of Nursing Section, convened by Sr. Catherine Gerard, contained among other things a recommendation that a School of Nursing Adviser be appointed for Nova Scotia as a first step towards establishing the qualifying examinations. A committee, composed of M. Jenkins, M. Miller, L. Grady and Sr. Gerard, was appointed to give further study to the recommendation and to obtain information as to qualifications required and salaries paid by other provinces for similar appointments.

The question of working hours and salaries in effect in hospitals throughout the province was studied and discussed, and it was recommended that a minimum and maximum salary scale for nurses be drawn up. It was also recommended that every school of nursing in the province give each student nurse a minimum of three weeks' vacation in each year of her course and that, if possible, this be extended to four weeks.

During the year the Legislative Committee examined and discussed the original draft, and a second draft, based upon amendments, suggested by all provinces, of the proposed Constitution and By-laws of the C.N.A., and forwarded comments and suggested amendments. Consideration was also given by this committee to the proposed Nurse Practice Act and the proposed new Constitution and By-laws of the R.N.A.N.S. Out of the report of the C.N.A. councillor came the question of shortening courses for student nurses, all of the provinces having been asked by C.N.A., when drawing up their new by-laws and constitution, to make provision for a shortened term. It was, therefore, resolved that the Legislative Committee make provision for the nurses taking the three-year course at these special schools to be allowed to write the registered nurses' examinations.

The report of the Labor Relations Committee indicated that a meeting had been held in Halifax with the representative of the Civic Employee Federal Union, Local No. 143, with respect to the appointment of a bargaining agent for the association to negotiate with the Regional War Labor Board. While a sympathetic hearing was

given to this representative it was felt that the association, being composed of professional members, had nothing to gain by making such an appointment, in the belief that the association itself could act in the best interest of its members.

The Post-graduate Course Committee reported that definite progress has been made and prospects are bright for the establishment of post-graduate courses in public health, teaching, supervision and administration at Dalhousie University, Halifax.

The appointment of an adviser-registrar was approved and a Selections Committee was appointed to advertise for and consider applications for such position.

The following officers were elected for the ensuing year: president, Lillian Grady; vice-presidents, Lenta Hall, Maisie Miller, Sr. Catherine Gerard; recording secretary, Frances MacDonald; corresponding secretary and treasurer, Nancy Watson. Section chairmen: General Nursing, Mollie Stevens; Public Health, Marion Shore; Hospital and School of Nursing, Sr. Mary Beatrice. Standing committees: Program and Publications, Mrs. Charles Bennett; Legislative, Marjorie Jenkins; Nominating, Josephine Betz; Library, Kathleen Harvey; adviser to registrar, Sadie Archard.

The thanks of the association are extended to Mrs. N. S. Sanford for the excellence of arrangements in connection with the annual meeting; the Ladies Hospitals' Aids of Amherst and Springhill for entertaining at afternoon tea, and to the ladies of Trinity St. Stephen's United Church for an excellent dinner at which Dr. Charles Gass, of Mount Allison University, Sackville, N.B., was guest speaker.

NANCY H. WATSON
Registrar, R.N.A.N.S.

Department of Veterans Affairs

There has been nothing in *The Canadian Nurse* concerning the Department of Veterans Affairs for several months—I hope you noticed! The reason was not because the Treatment Services have run out of news but rather because the editor has been so generous to us during the preceding months, and also because she was pressed for space for the C.N.A. biennial reports. But here we are again, and we hope to say "Hello" every month hereafter.

Matrons' Conference: The matrons from the D.V.A. hospitals across Canada, with the exception of Miss S. C. MacIsaac, of Camp Hill Hospital, Halifax, met in Ottawa on June 28 and 29. This was the first Matrons' Conference ever held by the Department of Veterans Affairs. We are hoping it will be a biennial affair from now on, or at least until we have returned to more normal times. After the conference in Ottawa, the majority of our matrons were able to attend the meetings of the Canadian Nurses Association and Nursing Sisters' Association in Toronto.

The army helps us out again: July 31 was set as the last day that the army could possibly help the Departmental Hospitals with army staff, or so it seemed until about four days before that date. However, as usual the army didn't let us down and help was guaranteed for the remainder of the summer, at least, in order to let those army nursing sisters who are coming to the D.V.A. take their discharge and their well-earned leave, before starting in on the next stage of their nursing careers. The taking over of an army hospital, which is full to capacity and working at top speed, is far from an easy undertaking to say the least, but when many of the key people on the army staff are some of those whom we hope will become key people on the new D.V.A. staff, it is well-nigh impossible. However, that is what has been attempted this past summer at Quebec Veterans Hospital, formerly St. Charles Military Hospital; Montreal Veterans Hospital, formerly Queen Mary Road Military Hospital; Malton Convalescent Hospital; Hamilton Veterans Hospital; Crumlin, formerly London Military; Brandon Veterans Hospital; Regina Veterans Hospital; and Vancouver Military Hospital which has now become a part of Shaughnessy Hospital in Vancouver.

This has all been accomplished, as well as the setting up of another tuberculosis hospital at Sussex, N.B., opening a 125-bed addition at Camp Hill Hospital, Halifax, making

arrangements to open part of Sunnybrook in Toronto, opening the new chest wing at Shaughnessy, not to mention the new Victoria Veterans Hospital, all of which is supposed to be ready by this fall. Is it any wonder that D.V.A. keeps calling for nurses and more nurses?

A special message to nursing sisters of World War II: Through the facilities of the Rehabilitation Branch, the Department of Veterans Affairs, a special questionnaire is being sent to all nursing sisters who served or are still serving in one or other of the three services. It is the wish of the Rehabilitation Branch that the questionnaire be answered by all enlisted nurses. It is hoped that full and correct data will be available after the summarization of the returns by the Statistical Branch of the Department of Veterans Affairs. Too often, unfortunately, the right address of the individual is not at headquarters and I am, therefore, asking all nursing sisters who read this statement to do their utmost to pass on the word to any nursing sisters they know. It is only by the full co-operation of everyone that such a questionnaire serves its real purpose. If you are a nursing sister, and if, by the time you read this in *The Canadian Nurse*, you haven't received a questionnaire, please drop me a note, or get in touch with your own matron-in-chief and a questionnaire will be sent to you at once.

We hope you will be just as interested in knowing the answers to these nursing sister questions as we are, and we promise you a full report in *The Canadian Nurse* at the earliest possible date. Needless to say these are confidential records, and the report will be entirely statistical in nature.

—AGNES J. MACLEOD

Nursing Sisters' Association of Canada

During the first week in July the *Toronto Unit* was hostess to the delegates to the biennial meeting of the Nursing Sisters' Association of Canada, held at the Royal York Hotel. The dinner, with nearly four hundred present, proved to be the highlight of the meeting. Mrs. Gilbert Storey, president of the Toronto Unit, was in the chair. Col. Agnes Neill, Matron-in-Chief, R.C.A.M.C., introduced the guest speaker, Miss Anna Schwarzenberg, executive secretary of the International Council of Nurses. Miss Schwarzenberg had recently returned from a tour of the devastated countries and her talk proved most enlightening as she depicted the great need of assistance for the rehabilitation of the nurses in these stricken areas. It was gratifying to have present many nursing sisters representing the three services.

Maud Wilkinson, president of the national executive, later conducted the business meeting, when several projects were voted upon, including the following: A National Rehabilitation Fund has been established. Donations of $500 each have been made by Toronto and Vancouver, together with a personal gift of $600, bringing the total to date to $1,600. Approval was given to the establishment of club houses for nursing sisters if the Red Cross is able to provide residences. Local units will be responsible for maintenance where club houses are located. The N.S.A. of Canada is to be nationally incorporated. A new directory is to be compiled, with Maud Wilkinson as registrar.

Delegates present from out-of-town included: Miss Archer, Halifax; Miss Titus, Saint John; Mrs. Ramsay, Montreal; Miss Bagnall, Ottawa; Betty Pense, Kingston; Miss Cowan, Hamilton; Mrs. Campbell, London; Miss Barton, Winnipeg; Mrs. Parker, Saskatoon; Miss Morton, Calgary; Miss Panton, Vancouver; Miss Rossiter, Victoria.

Votes of thanks were extended to Miss Wilkinson and the national executive, the Toronto Unit, and the editor of *The Canadian Nurse* by Misses Morrison, Barton, and Mrs. Crummy. Conveners for the dinner were the social secretary, Edith McAlpine, assisted by Mrs. Jack Bell and committee. The next biennial meeting will be in 1948 at Saint John, N.B.

Another enjoyable event was the reception and tea given by Mrs. Albert Matthews, wife of the Lieut. Governor, at Parliament Buildings, Toronto. Mrs. Storey received the guests with Mrs. Matthews. His Honour later welcomed those present. Nursing sisters of World War I and II assisted. In attendance were Lieut.-Col. Norman Alexander, Lieut.-Col. Baptiste Johnston, and Lieut. Stewart Reburn.

The Truth Drugs

A. Owen-Flood, L.R.C.P.I. and L.M., L.R.C.S.I and L.M.

From time to time our papers and journals splash across their pages accounts of confessions of crime extracted by means of the "truth drug." In a recent issue the name of this marvel has been disclosed, pentothal sodium, one of the barbiturate groups. The makers, however, claim no such virtue for this substance, thus adding to the confusion of the public as to what exactly a truth drug is, and how it operates.

Let us, then, get this fact straight once and for all. Pentothal sodium, as many now know, is a basal anesthetic introduced into the blood stream by intravenous injection usually. It has no property in itself of producing "truth."

Psychic States

No drug or gas produces a confession, but they do produce a state of affairs where the subconscious mind rises, as it were, to the surface of the mind's lake, and that crime or anxiety with which it is most burdened, it tends to shed, and this is the truth. This state of mind is known as the *psychic state*, or a state of hypnosis. Any drug capable of producing analgesia, loss of pain sensation, or the lightest anesthesia will produce this condition. It is a definite stage in most types of anesthesia.

Drugs used for the purpose of extracting confessions are by no means a modern invention. Opium, hashish, and many others have been used in ancient times. The early recognition of the truth of the wise saw *in vino veritas* prompted the use of alcohol for this purpose; indeed, many a criminal, worn out by the terror of the hunted, self-administers this well-known "truth extractor" and presently finds himself in the hands of the law.

The stage of drunkenness, early anesthesia, hypnosis, and oncoming death are identical. Why the truth is so easily obtained in these states can be briefly explained. The subconscious mind holds the record of all our life experiences, good or bad. The latter are buried where they seldom reach the conscious level: in other words we tend to forget or put out of our mind unpleasant happenings, which, when brought to mind, give us a sense of pain and guilt. So, like the battered corpse of his victim, the murderer buries his evil thoughts, but these, like the body in the case, tend at times to come of their own account to the surface, and this they do in his dreams, and in his waking state, where they are sternly vanished by his conscious mind.

Conscious Control Abolished

The "truth drug" brings about the state where this conscious control is abolished and concealment of all major and guilty experiences becomes impossible. The state renders the individual particularly sensitive to suggestion and the merest hint will bring forth a full confession. This is not so surprising when we realize that there is present in most subconscious minds the urge to confess. This is motivated by two main reasons:

1. As an escape from the misery and pain of the hunting, haunting, and the grave anxiety of the criminal.

2. Bravado and the irresistible urge to boast and display the cleverness of his concealment of the crime.

There is one type of murderer uninfluenced by the application of drugs — the criminal lunatic. The mentally diseased live mainly in the subconscious life, which is to a great extent out of their conscious control. This is one of the reasons why the pursuit of this type of murderer is extremely difficult, as the crime is usually planned and committed with devilish cunning and with no apparent motive whatever.

The introduction of a drug in these cases is not easy, and the "confession", if elicited at all, would be unreliable as to the truth.

—*Nursing Mirror*

STUDENT NURSES PAGE

Arteriovenous Aneurysm

L. GARLAND

Student Nurse

School of Nursing, Regina General Hospital, Sask.

PTE. A was admitted to the military ward with a diagnosis of old gunshot wounds of the left side of his body. The injury had been received while he served in Germany some months previously. General examination showed multiple scars on the left side extending from the toes to his shoulder. When the scar areas were palpated hard, pellet-like structures could be felt under the skin's surface.

When Pte. A was admitted he had no complaints. He was able to walk without the aid of crutches or cane with very little discomfort. His temperature, pulse, and respirations were normal.

Auscultation of the left leg with a stethoscope in the middle and the lower third on the lateral side revealed an interesting detail. There was a dull roar or "churning-like" sound heard. This was due to the fact that the arterial blood and the venous blood were mixing in attempting to reach and return from the lower extremity. It was also noticed that a pulsating sensation could be felt with the hand.

X-rays were taken of the left foot and ankle in anterior, posterior, and lateral directions. The examination showed numerous fragments of metallic density scattered throughout the soft tissues and bony structures of the foot. The fragments measured from less than a millimeter in diameter up to approximately a centimeter. They extended from the region of the metatarsals to the knee joint. No evidence of fracture or dislocation of the bones of the foot could be seen. There was no evidence of osteomyelitis. The tibia and fibula appeared normal with no fractures. The knee joint appeared normal. The patient was booked for resection of an arteriovenous aneurysm.

What is an aneurysm? An aneurysm is a saccular dilation of a blood vessel. It is not usually looked upon as a surgical condition, but there are two types which respond to surgical therapy. Traumatic aneurysm is produced by an injury to the wall of an artery. A stretching of the injured portion of the arterial wall occurs with the formation of a gradually enlarging sac. This type of aneurysm appears in the extremities, where injury is most frequent. It may be treated either by excision of the enlarged, damaged portion of the artery or by repair of the arterial wall, an operation known as aneurysmorrhaphy. The second type of aneurysm, which is frequently treated by surgery, is known as arteriovenous aneurysm. This is the type with which we are concerned in this case. This may result from a congenital communication between the veins and arteries, or from an injury in which healing results in communication between them. This was the case with Pte. A. The

symptoms of this disease are due to this communication; the veins pulsate and become widely dilated. In the surgical treatment of this lesion an attempt is made to divide the communication. It may be possible to sever it directly or it may be necessary, in some cases, to excise the entire segment of vessel containing the communication.

When surgical intervention was started, it was found necessary to resect the damaged portion. A vertical incision by the popliteal space to angle structures exposed the popliteal fossa. There was a marked amount of scar tissue formation in the middle and lower third of the leg. Ligation, above and below, of both vein and artery was done. Because of the scar tissue formation and the difficulty in removing it, the aneurysm could not be retained as a good pathological specimen. The incision was closed with catgut and dressings of gauze were held in position with elastoplast bandage.

Due to loss of blood and the length of the operation, an intravenous of 5 per cent glucose in normal saline was commenced in the operating-room. On return to the ward, 500 cc. of blood plasma were given. Until the patient regained consciousness oxygen was given continuously. The foot of the bed was elevated eight or ten inches to relieve the pressure of blood trying to pass through the leg. The leg and foot were also to be kept exposed to the air and under no consideration were hot water bottles to be applied. The doctors wanted to be certain that the circulation was reaching the limb by means of the remaining vessels.

Morphine gr. ¼ was given for pain for the first five days then only nembutal gr. 1½ was given at bedtime.

On the ninth day, the sutures were removed. The wound was in good condition and well healed. In twelve days the patient was out of bed on crutches. Pte. A was discharged on the eighteenth day. He would remain on crutches for a time in order not to put too much weight on the veins and give them an opportunity to heal. Pte. A left the hospital in much better condition to work than when he entered.

The Nurse as a Social Worker

(*Continued from page 876*)

Social service gives one the opportunity of working with all of the classes and types of people who make up our communities. To have a share in the building of our nation, through contact with widely varied individuals, to enter their homes and help them to solve their seemingly mountain-high problems, be they of health, wealth, or morality, is a rare privilege. The nurse can render unlimited service, can gain increasingly worthwhile knowledge, and can receive inward satisfaction that cannot be estimated.

Social service branches out into diffuse lines of public service and the knowledge gained through them is of lifetime benefit to the worker. The social worker delves into the study of law, gains an insight into all standards of living, and is afforded an opportunity to develop her initiative as she strives for ways and means to lighten burdens, better home conditions, and strengthen moral character. Non-temperance in the home as well as in industry portrays a despairing picture and a perplexing problem at times. The firm, but understanding sympathy of the social worker comes oft-times almost as an answer to prayer. Other branches of work lie in the direction of child and youth discipline, and the perplexities of child and adult delinquency. Proper nutrition amid food scarcities is a common problem and one with which the nurse is more familiar than other social workers would be. Attention to furthering the control

of tuberculosis, cancer, and the venereal diseases, and bringing these vital matters before the public could be well handled by the nurse. Her background of nursing education fits the graduate nurse to take her place among the social workers who are striving towards the making of better citizens and our Canada a better place in which to live.

Letters from Near and Far

Editor's Note: Helena Reimer, who wrote the following letter, is so far the only Canadian nurse with UNRRA in the China expedition. Miss Reimer is a graduate of the Winnipeg General Hospital and, before joining UNRRA, was clinical instructor in surgical nursing there. Miss Reimer served with UNRRA in Egypt before going to China.

I have been working on a refresher course for the Formosan nurses all day. How far removed we are here from the rest of the world! Formosa is without doubt the most beautiful spot in which I have lived. After two weeks of it I still feel as though I am sleep-walking. The wooded hills with their beautiful tropical plants, orchids, that you can pick, and many others; the terraced rice paddies in the lowlands; the winding mountain roads; the lazy rivers winding in and out through fields of rice, past gardens, and hyacinth fields; the villages with half-naked little children playing on the streets; the starry sky at night and the soft scented evening breezes—it is all just too much to take for granted.

We are twelve people here in the UNRRA Regional office. Our office is in Taipeh. Our home is a lovely Japanese hotel on a hillside nine miles out of town.

We each have our own apartment—living-room, balcony, and bedroom. My floor is covered with lovely white matting. In the centre of the room I have a beautiful teak-wood table with cushions around it on the floor. In one corner on a raised platform is a solitary vase with some lovely flowers. On the wall behind is a most beautiful Japanese scroll done by one of their famous artists. In a little niche in one corner, which used to be an altar, I have my books.

In my bedroom all I have is a mattress on the floor with a mosquito net over it and a tiny dressing-table at which I have to sit cross-legged to do my face.

Three of my walls slide in and open up onto my balcony which has glass sliding doors. Outside the balcony I have a little garden.

We eat western style in a western dining-room. But on the second floor we have a beautiful large Japanese room in which we entertain and eat meals sitting on the floor when we feel like celebrating. No one wears shoes in houses here either. You leave your shoes at the door and put on grass slippers. These you wear in hallways and in rooms that have plain floors. We remove them to step into our apartments. So I pad around on bare feet on my matting. Our servants are all girls—most adorable but not very efficient. However, they see to it that there are lots of flowers around.

This all sounds luxurious and it is a delightful way of living, but we work for it. I have worked as hard here as I did at the W.G.H. I spent my first two weeks making a health survey of Taipeh and surrounding country because I was the only one of the medical staff here. Then I worked on allocations of medical supplies, crawled around shipping warehouses, etc., trying to get things straightened out. As we have no welfare representative as yet, I had to start on some relief projects as well.

It is amazing what an ordinary W.G.H. nurse can do if put to the task. I am really quite proud of my welfare work. Knowing that in China it takes fifty years to make a plan, I was surprised at myself when I found myself in charge of a milk feeding centre on my third day here. But apparently my western straightforwardness was accepted and taken at face value.

There are only two registered nurses on the island beside myself, with a population of about six million. These two girls were trained at St. Luke's in Japan and are good nurses, I think, although they have done very little nursing since they graduated.

The Formosan nurse is a cross between a technician and a maid. In the very elaborate curriculum that was set up for the nursing schools there was not one course in "nursing care."

I have not seen any nursing care being given in any of the hospitals that I have visited so far. The nurses spend their time pouring tea for the doctors and giving injections in the out-patient department. One 200-bed hospital has twenty internes but the nurses still do all the O.P.D. injections. Every patient coming in gets an injection of some kind. The nurses are practically illiterate to start with, of course, and are classified as menial labor. One of their courses of instruction was called "Spiritual Values." This consisted mostly of advice on obedience to doctors and other authorities.

The Chinese National Health Administration plans to open a central school of nursing in Taipeh next September. As yet, there are no buildings, no equipment, no teachers, no supervisors in hospitals or rather no nurses in hospitals. That, in short, is my work for the next little while. The representative of N.H.A. here, a doctor from P.N.M.C., presented me with the curriculum he had set up for this school. It is a master-piece of Chinese planning but something beyond this world—certainly beyond the comprehension of the Formosan middle school student.

It interested me that the doctor had forgotten that a day has only twenty-four hours. According to his plan, the nurses would spend eighteen hours of their day in classrooms or in preparing for classes, and another eight hours on the wards. So the UNRRA nurse is now working on a curriculum to present to the doctor. He very politely asked for her advice.

I felt so badly about not being able to go to church that some of our people found me the native Christian church. The native Christians here are Presbyterian or Catholic. The Canadian Presbyterian Mission Board has had missionaries out here since 1872. They had three hospitals, a leprosarium, a high school, and a seminary. The missionaries all had to leave in 1941 and the hospitals had to close due to war damage. I will be glad when they come back to re-open them. That will help me out in my plans.

Well, anyway, the service was held in the native dialect but they sang the good old hymns and we all joined in in English. The pastor's wife conducted a nice little choir and his daughter sang a solo. I felt quite at home and happy.

We are being entertained at long dinners by Chinese officials and we entertain, too. There are some U.S. Government people here now, the consul, etc., and of course we white people stick together closely.

Book Reviews

A Manual of Tuberculosis, Clinical and Administrative, by E. Ashworth Underwood, M.D. 524 pages. Published by E. & S. Livingstone Ltd., Edinburgh. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 3rd Ed. 1945. Price $4.50.

Reviewed by Trenna G. Hunter, R.N., B.A.Sc., Director of Nursing, Metropolitan Health Committee, Vancouver.

In this new edition of the Manual, Dr. Underwood has given a very comprehensive account of the varied aspects of the disease. With true British thoroughness each aspect is discussed in detail and new chapters have been added. These deal with the evolution of pulmonary tuberculosis, allergy and immunity as related to tuberculosis, x-rays and radiography as applied to tuberculosis, the mental aspects of the disease, methods employed as a routine in the clinical laboratory, social medicine and tuberculosis, and tuberculosis and war.

Dr. Underwood writes in an easy style and his chapter on the Mental Aspects in Tuberculosis is particularly helpful to those dealing with patients in hospital. He includes here a section on the treatment of the ex-serviceman. His section on the attitude of the staff is typical of his commonsense attitude towards treatment:

"Members of the staff of the tuberculosis hospital will find that it will be useful if they were slightly on their dignity. This attitude should not be evident, but the impression should be left that the staff are above the petty problems which unfortunately mean so much in the lives of long-stay patients. The

patients should feel, however, that the members of the staff have their interests sincerely at heart. The progress of a patient depends a great deal on the attitude of his doctor and his nurse. If he suspects that he is not being taken seriously, he will have an additional handicap to overcome. The nursing staff can be trained to develop the correct attitude.

"It used to be said that 'for tuberculosis we prescribe, not medicine, but a mode of life.' Although treatment is becoming more specialized every year, there is still a great deal of truth in this saying."

Although his chapters on rehabilitation and social medicine deal with the British plans, they are carefully and clearly described, and give us a good picture of what is being done in Great Britain.

The figures contained in the chapter, Tuberculosis and War, are particularly revealing, and, of course, up-to-date.

As Dr. Underwood states himself in his preface, he offers no apology for reducing to a minimum observations on the physical diagnosis of chest conditions which are more easily studied from standard works. Thus, he deals at greater length with the practical details of management of patients on the wards, especially from the doctors' point of view. Too often he feels these details are relegated to the nursing staff.

This Manual should be read with interest by doctors, nurses, and laymen interested in the administration of tuberculosis hospitals.

Initiation à la Médecine, par le Dr. Georges Hébert, professeur agrégé de l'Université de Montréal; médecin régulier de l'Hôpital Notre-Dame. Publié par les Editions de l'Arbre, Inc., 60 rue St. Jacques, Montréal 1. 1946. Reliure, toile, comprenant 24 figures; dessins schématiques par le Dr. M. G. Manseau. Prix $3.50.

Compte rendu par Suzanne Giroux, visiteuse officielle des écoles d'infirmières, A.G.M.E. P.Q.

Le livre, composé de 463 pages, est divisé en douze chapitres. Les quatre premiers sont destinés à l'étude des maladies des différents appareils de l'organisme, sauf l'appareil nerveux; puis on y étudie successivement les maladies de la nutrition, les carences vitaminiques, les rhumatismes, l'allergie, et les maladies contagieuses. Chacun des chapitres

est précédé de notions anatomiques et physiologiques se rapportant au sujet à étudier.

Dans l'étude des maladies, de nombreuses notes explicatives viennent jeter une nouvelle lumière; ce sont des jalons qui permettent à l'élève de demeurer dans le bon chemin, de pouvoir suivre l'auteur. Là, où sa formation scientifique imparfaite lui fait trouvé de trop grande difficulté ou l'empêche de rattacher tel fait à tel autre, l'on trouve toujours juste au bon moment, au bon endroit, une de ces petites notes explicatives. Certaines maladies que l'infirmière ne rencontre que très rarement sont décrites dans ce livre. Si la connaissance des symptômes et des traitements de ces maladies semble moins pratique à l'infirmière, elle les lira tout de même avec intérêt et saura référer à son livre lorsqu'un de ces rares cas se présentera soit dans sa pratique privé ou à l'hôpital.

L'on ne saurait trop féliciter le Dr. Hébert d'avoir indiqué à la suite du traitement le rôle de l'infirmière. Le plan du livre est exposé au début du volume et à la fin l'on trouve un petit lexique facilitant l'étude et un index alphabétique. Les dessins du Dr. Manseau illustrent bien la pensée de l'auteur, impossible de ne pas comprendre, de ne pas saisir ce que veut dire le maître, en regardant ces schémas, prenons par exemple le schéma à la page 297, physiologie des glanges endocrines.

Au point de vue pédagogique les institutrices admireront la logique du plan, la psychologie des notes explicatives, et la bonne co-ordination existant entre les différentes matières du programme et l'étude de la médecine.

Ce livre montre en plus de la haute culture médicale du Dr. Hébert, sa grande expérience dans l'enseignement aux infirmières.

Vitamin E for Heart Disease

Large, concentrated and continual doses of vitamin E for treatment of scores of heart disease cases have been used and observed by several London, Ont., and district doctors, and in Victoria Hospital, and have proven effective in bringing quick and sometimes dramatic relief of the disease. The doctors discovering this new treatment do not claim that administration of the preparation will wholly restore a damaged heart, but do contend that vitamin E taken continually will bring about vast improvements.

– *Canadian Pharmaceutical Journal*

Preview

In this day of fuller understanding of the cause of scarlet fever, it is difficult to realize that it is not so long ago since the good mother caring for her sick child at home used to hang a sheet, suspended in a pan of disinfectant, over the doorway of the sick-room. This moist sheet was supposed to intercept the particles of desquamated skin, believed to be the offending agent in the spread of scarlet fever. Six or seven weeks of quarantine was the rule. Recent developments in this field have led to a marked change in even the newer practices in controlling this disease. **Dr. John S. Kitching** will outline present day medical thinking for us next month.

Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the various branches of the Victorian Order of Nurses for Canada:

Winnifred Dawson has resigned from the National office staff and plans to retire from active nursing. She is succeeded by *Elisabeth M. Reed.* (Please see next month's "Interesting People" page.)

Appointments: *Bessie Soutar* (who was granted leave of absence from the Order in 1943 to serve in England with the British Civil Nursing Reserve) as nurse-in-charge at Sudbury; *Bernice Gordon, Christine Lund, Margaret Neilson,* and *Margaret Stone* (University of British Columbia public health course) and *Gertrude Dickie* and *Helen Irving* (McGill University public health course) to Vancouver; *Mrs. Dorothy Wagg* (University of Toronto School of Nursing) to York Township; *Ruth Stockley* and *Muriel Martin* (University of Manitoba public health course) to Winnipeg; *Mary Griffiths* and *Margaret Sanderson* (University of Toronto public health course) and *Mary McMahon* (University of Western Ontario) to Toronto; *Barbara Logan* and *Alyce MacKenzie* (McGill University public health course) and *Elaine Bevan* (University of Western Ontario public health course) to Montreal; *Miriam McLeod* and *Edith Gaylor* (McGill University public health course) to Victoria; *Ruth Arthur, Mary Blandford* and *Josephine Sweet* (University of

Western Ontario public health course) to Border Cities.

The nurses who received Victorian Order scholarships have completed courses in public health nursing at the following universities and have been appointed as indicated:

UNIVERSITY OF TORONTO: Toronto: *Phyllis Beardsall, Mary Clancy, Violet Dick, Helen Gowdy, Velma Martin, Adella Matusaitis, Hilda Tackaberry, Edna Valiquette, Mary Whiteside;* Chatham: *Evelyn Boyd;* Amherst: *Frances Hewgill;* Gananoque: *Ethel Irwin;* Port Arthur: *Ruth Kirkpatrick;* Dartmouth: *Olwin MacInnis;* Dundas: *Edith McKerlie;* York Township: *Violet (Mabee) Putman;* Sackville: *Edith Rose;* Hamilton: *Eva Secord;* Ottawa: *Gwen Watt;* Aurora: *Marjorie McIntosh.*

UNIVERSITY OF WESTERN ONTARIO: Toronto: *Barbara Shook;* Collingwood: *Betty Brown;* Timmins: *Claire Hicks;* New Liskeard: *Doris* Kirkwood; Border Cities: *Mae Leydon, Helen Thompson;* Bridgewater: *Annie Wade.*

MCGILL UNIVERSITY: Halifax: *Margaret Lownds;* Cobalt: *Margaret Joyce;* Pictou: *Marion MacKaracher;* Montreal: *Patricia Merriman, Evelyn Weaver;* Newcastle: *Bettie Norris;* Smiths Falls: *Marjorie Salter.*

UNIVERSITY OF ALBERTA: Kirkland Lake: *Eleanor Jamieson;* Fort William: *Hilda Law;* Sudbury: *Ruth Sheppard.*

UNIVERSITY OF BRITISH COLUMBIA: Burnaby: *Margaret Forry.*

UNIVERSITY OF MANITOBA: Winnipeg: *Irene Halford, Merle Pringle.*

Transfers: *Laura Wall* from New Liskeard to be nurse-in-charge at Kingston; *Jean Conlogue* from Montreal to be nurse-in-charge at Woodstock, N.B.; *Gladys Hergett* from Halifax to be nurse-in-charge at Liverpool; *Evelyn Armstrong* from Truro to be nurse-in-charge at Sydney; *Mona Smith* from Liverpool to be nurse-in-charge at Truro; *Margaret Holder* from Amherst to Montreal; *Janet Wolverton* from Vancouver to Hamilton; *Margaret Ross* from Pictou to Vancouver.

Resignations: *Lois Skinner* from Toronto, *Helen Decary* from Lachine, *Beryle Crawford* from Waterloo, *Mary Plishka* from Oliver, and *Jean Keam* from Border Cities to be married; *Evelyn (Oldershaw) Carlyle* from Burnaby; *Marion (Scholfield) Fair* from Cobalt; *Marion (Spencer) Fathers* and *Elsie (Cropper) Waller* from Border Cities; *Margaret (DeLaurier) Bastedo* from Brantford; *Dorothy Paulin* from Collingwood and *Helen Waring* from Montreal to take up other work; *Ellen Linton* from Smiths Falls to return to Ireland; *May Deane-Freeman* from Edmonton to take post-graduate study; *Gweneth Grant* from Toronto; *Myrtle (Brown) McNeil* from Halifax; *Mary Craig* from Hamilton; *Jean Burgess* from Sackville; *Lucille Beaudet* from Sherbrooke.

Victorian Order scholarships, for the purpose of assisting nurses to take post-graduate study in public health nursing, have been awarded to the following nurses who are attending the universities indicated:

UNIVERSITY OF TORONTO: *Dorothy Buck, Lois Crawford, Bernice Egerdee, Nita Enns, Margaret Hanna, Olive Hayes, Marion Johnston, Frances Jolliffe, Helen Keith, Heather Matthews Muriel Morgan, Mary Reynolds, Margaret Schmaus, Maureen Seymour, Helen Smith, Edith Stansfield, Hope Vanderwater, Margaret Whebby, Margaret Wishart, Ellen Pocock.*

MCGILL UNIVERSITY: *Margaret Wanless, Willa McClement, Vivian Sharpe, Joan Tallon.*

UNIVERSITY OF MONTREAL: *Jacqueline Doyon.*

UNIVERSITY OF WESTERN ONTARIO: *Elisabeth Berrybill, Gladys Doran, Fay J. Dickie.*

UNIVERSITY OF MANITOBA: *Gertrude Brandes, Marguerite Leahy, Rose Redding, Marion Hellyer.*

UNIVERSITY OF ALBERTA: *R. Laurie Fages,*

Phyllis Fraser, Constance Swinton, Eileen Williams.

UNIVERSITY OF BRITISH COLUMBIA: *Kathleen Davies, Elisabeth Hayden, Elin Johnston, Norma Kenney, Aileen Shaw, Kathryn Smyth, Margaret Whitecross, Irene Sheasby.*

COLUMBIA UNIVERSITY: *Christine MacArthur, Katherine Weatherhead.*

Help Yourself to Security

For years, the nurses of Canada have been agitating for some pension scheme which would be available to every nurse be she engaged in hospital, public health, or private duty. Repeatedly, committees have been formed to see what could be done. Always the same report has been made — a pension scheme to cover every nurse in Canada was not practical. It had to be planned on an individual basis.

Nurses are not universally good money-savers. Until recent years, many of them did not receive large enough salaries to permit them to salt away any very considerable sums of money. Then came World War II and the urgent drives sponsored by the Government of Canada to raise vast sums for the prosecution of the war. Thousands of nurses responded to these appeals and bought bonds. They bought War Savings Certificates. In many instances, these purchases were made through payroll deductions. The individual nurse received a pleasurable surprise when she stopped to reckon up how much had accumulated to her credit through these small regular purchases. A thousand dollars — two thousand dollars — quite a tidy nest-egg for the ultimate purchase of an annuity, to help to meet personal emergencies or to add to the comforts of life.

Perhaps even more important than these immediate blessings, the habit of saving, which was thus built up, has proven beneficial. It is the surest way to ensure future security, the basic urge which haunts us all. To foster this good habit and to provide a sound investment, the Government of Canada announces a new savings plan — Canada Savings Bonds.

The forthcoming bond offering will not have the urgent sales atmosphere of Victory

Loan issues, nor the use of the vast sales force which used to knock at practically every door in Canada. Except for the organization of payroll sales by employers, and a partial coverage of the general public by the staffs of investment dealers, nurses will act strictly on their own initiative. They will make up their own minds about buying and how much they shall buy.

The Canada Savings Bond, like the Victory Bond, will be immediately redeemable should the nurse need ready cash. Annual payment of interest by coupons instead of semi-annual will be a new feature. Because a favorable rate of interest is being offered, the amount held by any one individual will be limited. This will not affect any nurse very materially! Another difference in this issue is that each bond must be registered in the name of the owner. This is a distinct advantage as it will mean that the owner is fully protected in case of loss, theft, or destruction of the bond.

These are "serve yourself" bonds. It is up to each one of us to decide — do we want to ensure greater security — do we want to save money or do we not? It is up to each of us. Help yourself to security!

News Notes

BRITISH COLUMBIA

TRAIL:

Trail-Tadanac Hospital:

Margaret Heeney, who recently resigned as superintendent, has been succeeded by Vera Eidt. (See "Interesting People" in this issue.) Other resignations include Ellen Boland and Frances Craig.

PRINCE EDWARD ISLAND

At a recent quarterly meeting of the Prince Edward Island Registered Nurses Association splendid reports from the C.N.A. biennial convention were given by the president, secretary, and Mrs. L. MacDonald. Miss Campbell, of Portland, Oregon, was a welcome, guest.

Anna K. Bennett, instructress at the P.E.I. Hospital, recently resigned to be married. Mrs. Lois R. MacDonald has taken her place, with Elizabeth Jenkins as her assistant.

QUEBEC

MONTREAL:

Children's Memorial Hospital:

A farewell party for Audrey Edwards was recently held by the staff members, when she was presented with a leather writing-case. Laura Gray, of the Ottawa Civic Hospital, is returning to the staff to replace her. Bella Rosenbloom has joined the operating-room staff.

SASKATCHEWAN

MOOSE JAW:

The provincial government health unit is in the process of organization. The senior nurse in attendance is Miss Normandin.

General Hospital:

The alumnae association has donated a sum of money to the local chapter to be used for sending parcels to Dutch nurses. Clara Lennie attended the recent S.R.N.A. convention in Saskatoon. Marjorie Redmond and Elsie Fletcher recently attended a teaching and supervision institute, held at the University of Manitoba under the leadership of Miss A. Grant, of New York City. Betty Fisher and Jorgine Salte have returned as instructresses in nursing arts and science respectively, after completing a year's post-graduate work at the University of Manitoba. Alice Ralph has resigned from the teaching staff and is now matron at Union Hospital, Craik, Sask. Alice Skaftfeld has resigned as clinical supervisor, floor B, to go to the Toronto Western Hospital.

Providence Hospital:

Graduates of the Providence Hospital have succeeded in organizing their alumnae association and the following will serve as officers: honorary president, Rev. Sr. M. Raphael; president, Patricia MacKenzie; vice-president, Mrs. McCormick; press reporter, Mrs. Mary Hunt. It is hoped that the nurses will be moving into their new residence in the near future. Ruth Reid attended the recent S.R.N.A. convention in Saskatoon.

SASKATOON:

City Hospital:

Recent appointments to the staff include: Mildred Aassen as obstetrical supervisor; Maryann Kennedy as her assistant (formerly night supervisor at Medicine Hat General Hospital); Louise Baptist as assistant operating-room supervisor (two years with the R.C.A.M.C., No. 22, C.G.H.); Marie Cantin (served with No. 10, C.G.H., R.C.A.M.C., for three years) and Marion Steeves as operating-room scrub nurses; Winnifred Heath to the general staff. Mrs. Doreen (Greenwood) Lansdall, operating-room scrub nurse, and Mrs. Muriel (Brunsdon) Davidson have resigned.

St. Paul's Hospital:

The hospital and school were honored by a recent visit from Dr. Farish, of the American College of Surgeons. M. Bohl, former science instructor, is now nursing arts instructor at Hôtel-Dieu, Windsor, Ont.

YORKTON:

Mmes A. A. Chapman, D. Hamilton, and G. Yurkoski recently left Yorkton to make their homes in Moose Jaw, Regina, and Craven respectively. Mabel Johnson, of the obstetrical department at the General Hospital, has resigned to be married.

Positions Vacant

WANTED

OTTAWA CIVIC HOSPITAL

Associate Director of Nursing Service

With capacity for organization and leadership. The candidate should be, preferably, between 35 and 45 years of age, a graduate of a recognized School of Nursing and preference will be given to a candidate with a University Degree in Nursing or the equivalent in post-graduate work. Candidate must have ample administrative experience. Salary will be in line with the education and professional experience of the applicant.

Candidates should apply in the first instance in writing, and arrangements will be made for a personal interview. Applications should be addressed to the **Superintendent, Ottawa Civic Hospital.**

General Duty Nurses for Norfolk General Hospital, Simcoe, Ontario. Salary: $100 per month (including pay for O.R. call) plus maintenance. Increase at end of 6 months, $105, and at end of 1 year, $110. 8-hour day and 6-day week. Holidays with pay, sick leave and hospitalization. Additional $5.00 per month paid for 3:30 shift. Apply to Supt.

Assistant Residence Nurse by November 1. Apply, stating qualifications, to The Secretary, School of Nursing, University of Toronto, 7 Queen's Park, Toronto 5, Ont.

Registered Nurses for Tuberculosis Sanatorium. Urgent. Salary: $110 plus $19.70 Cost of Living Bonus, less $27.50 for board, room, and laundry. Superannuation. 31 days' vacation. Beautiful location; generous recreational facilities. Frequent bus service to town, 10 miles away. Apply to Supt. of Nurses, Tranquille Sanatorium, Tranquille, B.C.

Night Supervisor for 50-bed Maternity Hospital. Apply, stating qualifications, salary, etc., to Supt., Catherine Booth Mothers' Hospital, 4400 Walkley Ave., Montreal 28, P.Q.

Public Health Nurses for Bruce County Health Unit. Salary: $1,500 to $1,800 according to experience, plus car allowance. Apply to W. S. Forrester, Secretary, Paisley, Ont.

Registered Nurse for Medical Clinic in Central Ontario. Recent graduate preferred. Apply, stating age, experience and references, and enclosing recent photographs, in care of Box 22, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

Public Health Nurses for Lambton Health Unit. Apply to Ina I. McEwen, Supervisor, Board of Health Office, Sarnia, Ont.

Supervisor for Pediatric Dept. and vacancies for other **Graduate Nurses.** State school, date of graduation, details of experience, and references. Minimum gross salary: $125, with yearly increases, with higher scales for positions of head nurses, etc. Full particulars of benefits and terms of employment available on application to Miss Elizabeth Clark, Supt. of Nurses, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses for Miller Bay Hospital, situated on highway near Prince Rupert. 150-bed hospital operated by Dept. of National Health & Welfare. Salary: $118 per month, plus laundry, room, and board. Preference given to nurses having Sanatorium experience. Apply to Dr. J. D. Galbraith, P. O. Box 1248, Prince Rupert, B. C.

Registered Nurses for General Duty at Vancouver General Hospital, British Columbia. State in first letter date of graduation, experience, reference, etc., and when services would be available. 8-hour day and 6-day week. Gross salary: $125 per month living out, with annual increases up to 7 years, plus laundry. 1½ days sick leave per month accumulative with pay. Employees' Hospitalization Society. Superannuation. 1 month vacation each year with pay. Investigation should be made with regard to registration in British Columbia. Apply to Director of Nurses.

General Duty Nurses (3). Salary: $95 for day duty; $105 for night duty. **Supervisors:** one Medical and one Surgical. Salary: $115 per month. For 200-bed hospital. Full maintenance in beautiful nurse's residence. Railway fare refunded after 6 months' service. Apply to Supt., County General Hospital, Welland, Ont.

Public Health Nurses with agency specializing in Tuberculosis. Health education and case finding program. Home visiting and clinic duties. No bedside nursing. Experience in tuberculosis preferred but not essential. Nurses without Public Health training desiring experience in this field accepted on temporary basis. Apply to Royal Edward Laurentian Hospital, Dept. of Public Health Nursing, 3674 St. Urbain St., Montreal 18, P.Q.

Instructress of Nurses. Salary: $140 per month and full maintenance. **Night Supervisor.** Salary: $130 and full maintenance. **Floor Duty Nurses.** Salary: $100 and full maintenance. Apply to Supt., General Hospital, Kenora, Ont.

Science Instructor: Salary, $1,620 to $1,800 plus $300 bonus and C/L bonus. **Nursing Arts Instructor:** Salary, $1,320 to $1,500 plus $300 bonus and C/L bonus. **Night Supervisor:** Salary, $1,380 to $1,560 plus $300 bonus and C/L bonus. **General Ward Duty Nurses:** Salary, $900 plus $300 bonus and C/L bonus. Full maintenance charged at $25 per month. Uniforms and laundering supplied without charge. 3 weeks' vacation with pay after 12 months if continuing in service. 7 days sick leave with pay during 1st year; 2 weeks during 2nd year. Apply to Supt. of Nurses, Mental Hospital, Brandon, Man.

Assistant Night Supervisor for 78-bed General Hospital. Must have good working knowledge of Obstetrics. Apply, stating experience and salary desired, to Supt., Chipman Memorial Hospital, St. Stephen, N.B.

Graduate Nurses for General Duty nursing for St. Lawrence Sanatorium, Cornwall, Ontario. Maximum salary: $110 and maintenance, according to qualifications and experience. 48-hour week. 3 weeks' holiday with pay after 1 year's service. Applications should give full particulars as to qualifications, experience, etc. Personal interviews if possible. Apply to Supt.

Night Supervisor and **Assistant Night Supervisor** for 100-bed General Hospital in Western Ontario. Position open January 1, 1947. Apply, stating qualifications, experience, and salary expected, to Supt., General Hospital, Woodstock, Ont.

Administrative Assistant to Director of Nursing. The candidate must be a graduate of a recognized School of Nursing with an aptitude for nursing office routine. Apply in writing to Supt., Civic Hospital, Ottawa, Ont.

Superintendent of Nurses for Manitoba Sanatorium, Ninette, Man. (285 beds). General supervision over nursing, including affiliation courses about to be provided for general hospital undergraduates. Instructor employed and housekeeper. Tuberculosis experience preferred. Salary: $2,220 per annum, less $300 per annum for full maintenance. Holidays with pay. Pension plan for permanent employees. Apply immediately to Medical Director, Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Man.

Assistant Superintendent for Mount Hamilton Hospital, Hamilton, Ontario. Applicant must be experienced Obstetrical Supervisor. Apply, stating salary expected, in care of Box 23, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal, 25, P.Q.

Instructor of Student Nurses for small School of Nursing. Urgent. Full maintenance, including private room, meals, and laundry. Apply immediately, stating salary expected, to Mr. A. G. Middlemiss, Secretary, Board of Directors, Plummer Memorial Public Hospital, Sault Ste. Marie, Ont.